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IMPROVING HEALTH CARE IN AMERICA

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Current History

JULY/AUGUST, 1977 VOL. 73, NO. 428

In this issue, seven specialists evaluate the current health care system in the United States and analyze various suggestions for improving health care in America. As our introductory article points out, "Health insurance and public support for the care of the most needy segments of the population have reduced some inequities but have ignored other inequities and have contributed to the inflationary spiral of medical care costs. . . . Although programs have been developed that demonstrate some of the ways in which medical care delivery could be made more efficient and effective, no overall policies that would overcome the nation's major health care problems have yet been determined."

Health Care and the Patient's Needs

By Mary W. Herman

Assistant Professor of Community Health and Preventive Medicine, Jefferson Medical College

THE major trends in medicine in the United States in recent decades have led to increasing scientific research, the specialization of physicians, and the development of an elaborate technology for the diagnosis and treatment of disease. These developments have resulted in a greatly increased understanding of disease processes and significant advances in the treatment of many serious problems. Unfortunately, they have also caused some fundamental imbalances between the kinds of medical care that are available and the needs of patients; coupled with an emphasis on free enterprise, they have also produced cost increases that exceed those of any other sector of the economy. In terms of the system's impact on the health of its citizens, concentration on the treatment of disease rather than the maintenance of health may well be the most serious deficiency in the present allocation of resources.

One of the primary concerns of health care planners and consumers alike is the rapidly rising cost of medical care, especially since 1966, when federal funds for direct services were greatly increased through Medicare and Medicaid.[1] In spite of increased government financing of medical care for the poor and elderly and increased private insurance coverage by employers, direct expenditures by consumers rose from 5.9 to 7.8 percent of total private consumption expenditures between 1960 and 1973.[2] In addition, all segments of the population are not equally well covered by health insurance, and major gaps remain in the kinds of services that are covered by insurance.

Although almost 90 percent of the population have insurance for hospital and surgical care, only about one-third are covered for physicians' services provided in the office or home. Preventive services, routine eye and dental services, drugs and appliances (including such commonly needed appliances as eyeglasses) are seldom covered by health insurance. Coverage for mental health services is usually very limited.

Medicaid now pays for the medical care of many of the most needy families, but others with low incomes lack private health insurance and are not eligible for public assistance. In 1970, for example, only 40 percent of the households with family incomes of less than $3,000 had hospital insurance. Individuals in the poorest paid occupations are also least likely to have health insurance as part of their total benefit package. In many

[1]Titles 18 and 19 of the Social Security Act of 1965.

[2]The rising costs of medical care reflect both inflation and increased utilization. For most of the statistics in this section, see U.S. Department of Health, Education and Welfare (HEW), *Trends Affecting the U.S. Health Care System*, DHEW no. HRA 76-14503 (January, 1976), p. 157. See also John Krizay and Andrew Wilson, *The Patient as Consumer* (Lexington, Mass.: D. C. Heath and Co., 1974) for a more detailed analysis of medical care costs and financing.

states, Medicaid is restricted to households that are dependent on public welfare, and the adequacy of its pay schedules and the comprehensiveness of its coverage vary greatly throughout the country. As medical costs have escalated, the most common solution has been to reduce the size of the population eligible for Medicaid and to set limits on the fees that will be paid.[3] Many elderly people are also poor or living on limited incomes. The general inflation and rapidly rising costs of Medicare premiums, copayment requirements when medical care is used, and uncovered services and drugs cause many financial hardships to this group, whose need for medical care is great.

The unequal insurance coverage of different aspects of medical care costs leads to two major types of problems. For those with limited incomes, high costs deter individuals from seeking medical care early when treatment is likely to be more effective and less costly; and less pressing problems, such as dental and eye care needs, may be neglected altogether. At all income levels, the more complete insurance coverage of hospital care has encouraged both doctors and patients to favor hospital utilization wherever feasible, even if the treatment would be equally effective in a doctor's office or a hospital outpatient department.

Unequal coverage also appears to have contributed to considerable unnecessary surgery. Although the figures may be a little high, a recent congressional survey concluded on the basis of sample data that as many as 2.4 million unnecessary surgical procedures were performed in 1974, which resulted in 11,900 deaths.[4] As a condition for reimbursement, large third-party payors like the federal government and Blue Cross now require hospitals to conduct utilization review of the appropriateness of hospitalization and the need for the service provided. This is also a major function of the Professional Standards Review Organizations (PSRO's).

By 1970, serious consideration was being given to proposals for national health insurance programs that would alleviate many of these inequities and result in more rational utilization of services. There is serious concern over the inflationary effects of broadening insurance coverage, however, and until workable methods of cost control can be developed, it is unlikely that any comprehensive national health insurance system will be passed.

AVAILABILITY OF MEDICAL CARE

Since World War II there have been many signs that there were insufficient numbers of physicians available to meet the growing demands for service. Since 1950, however, the number of medical schools in the United States has increased from 79 to 114, and many schools have increased the size of their student bodies.[5] As a result, the overall physician-population ratio has been rising and is expected to reach adequate levels by 1980. By the 1970's, there was general agreement that the major problem was no longer the total supply of physicians but the declining number of generalists or primary care physicians and the uneven distribution of physicians geographically.[6]

Although the trend toward specialization in medicine is not a recent development, the proportion of medical graduates entering specialty training or engaging in restricted practices has increased greatly since the 1930's. The effects have been cumulative and are continuing, because general practitioners are now concentrated in the older age groups. In 1973, general practitioners constituted only 17 percent of all physicians. Specialists in internal medicine and pediatrics are the other major sources of primary care, but most graduate training programs in these specialties are not designed to train physicians for primary care, and increasing proportions of physicians certified in these areas are engaged in specialty care.[7]

The shift to specialization among medical graduates is a response to the increasing complexity of medical knowledge and technology, in combination with the higher incomes and prestige within the profession associated with medical specialization, teaching and research. It also reflects the kinds of students selected for admission to medical schools and the nature of their training, much of which occurs within teaching hospitals that are centers for the treatment of the more serious and esoteric conditions. The physicians being produced in turn tend to rely heavily on the sophisticated technology found in hospitals in their practice and to focus on the technical rather than the social or human side of medicine.[8]

In 1969, a new specialty of family medicine was established to train physicians specifically for primary care and to improve the earning potential and status

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[3]Karen Davis, "Achievements and Problems of Medicaid," *Public Health Reports,* July-August, 1976, pp. 313-315.

[4]Marvin M. Kristein, Charles B. Arnold and Ernst L. Wynder, "Health Economics and Preventive Care," *Science,* February, 1977, pp. 457-458.

[5]HEW, *op. cit.,* p. 342. However, about 20 percent of all physicians in 1973 were graduates of foreign medical schools, whose training and ability to communicate with English-speaking patients was highly variable. The Health Professions Educational Assistance Act of 1976 puts much stricter limitations on the entry of foreign graduates in the future.

[6]A primary care physician (or physicians) is defined as "one who establishes a relationship with an individual or a family for which he provides continuing surveillance of their health care needs, comprehensive care for the acute and chronic disorders which he is qualified to care for, and access to the health delivery system for those disorders requiring the services of other specialists." Coordinating Council on Medical Education, "Physician Manpower and Distribution," *Journal of the American Medical Association,* August 25, 1975, p. 880.

[7]*Loc. cit.*

[8]HEW, *op. cit.,* pp. 362-364; David Mechanic, *Public Expectations and Health Care* (New York: John Wiley, 1972), pp. 31-32.

of generalist physicians. The number of residencies in family medicine increased rapidly; by 1974, there were 219 residencies in this specialty, which attracted 20 percent of all medical graduates in that year. Efforts are also being directed toward the development of more suitable training programs for general internists and general pediatricians. Legislative pressure is being applied through the Health Professions Educational Assistance Act of 1976, which ties medical school subsidies (capitation payments) to schools to having some minimum proportion of their residents in general internal medicine, general pediatrics, and family medicine.[9]

The trend toward specialization has also led to a reduction in the proportion of physicians engaged in direct patient care and an increase in the proportion of those with hospital- rather than office-based practices. Between 1963 and 1973, the proportion of physicians engaged primarily in patient care declined from almost 90 to 80 percent. The number of physicians with office-based practices declined from 65 to 55 percent of all physicians.[10] Many office-based practitioners are also found near hospitals. Those with specialty practices, in particular, settle primarily in areas with larger population concentrations, with the result that by 1973 there were 172 physicians per 100,000 population in metropolitan areas but only 79 per 100,000 in non-metropolitan areas.

A direct relationship is also found between the economic level of an area and its supply of physicians. Doctors, like other people with relatively high incomes, are attracted to areas with good housing and schools and congenial neighbors; and unlike most employed people, they have considerable freedom in choosing where they will settle. Because of the unfavorable living and working conditions found in urban ghettos, these areas and isolated rural areas have the greatest dearth of office-based practitioners. Dwellers in the inner city areas may not be far removed physically from excellent medical technology in nearby hospitals and medical centers, but this delivery system is in many ways the least appropriate for persons of low income and low educational attainment.[11] Even physical access may be difficult for those living beyond walking distance.

Along with the decline in primary care practitioners, the number of patients seen per week has risen, and there has been a marked increase in the use of ambulatory services in hospitals, especially the emergency department.[12]

Despite the declining proportion of physicians in office-based practices, this is still the source of most ambulatory care. Group practices have been growing rapidly in number, but most of them are relatively small and the physicians in them work in much the same way that solo practitioners do. Under the small group or solo practice system, medical care is a private matter between the individual physician and his patients, subject to little oversight or control by other members of the profession. Physicians in larger, multi-specialty groups and those with hospital-based practices are more likely to engage in frequent exchanges of information and are subject to much more rigorous scrutiny by their peers.[13] Since a patient is poorly equipped to evaluate the technical quality of care provided, colleague controls over physician performance are essential for assuring reasonable standards of care.

The aspect of patient care that is most likely to suffer in larger group practices is the quality of the physician-patient relationship and the physician's responsiveness to the patient's concerns and convenience.[14] This appears to result both from the greater dominance of professional opinion that stresses the technical aspects of medicine and, in some cases, from the development of rigid bureaucratic structures. The latter are particularly characteristic of hospital clinics, which developed primarily as training sites and sources of care for indigent patients. The sustaining aspects of medical care are also likely to be neglected by overworked physicians who allow little time per patient visit.[15] Allowing nurses, nurse practitioners and physicians' assistants to provide many aspects of patient care that traditionally are restricted to physicians would help relieve pressures on physicians. Many studies have demonstrated that less highly trained health workers can safely carry out many routine aspects of patient care, are in many cases better able than physicians to communicate with patients and meet their needs for emotional support, and are usually acceptable to patients whether they are working in small or large group practices.[16] The organization of medical care delivery is under the direction of physicians, however, and thus

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[9]*Health Manpower Report,* vol. 5, no. 22 (October 27, 1976), p. 2.

[10]American Medical Association, *Socioeconomic Issues on Health,* 1974, p. 16.

[11]Mary W. Herman, "The Poor: Their Medical Needs and the Health Services Available to Them," *Annals of the American Academy of Political and Social Science,* January, 1972, pp. 15-21.

[12]In 1974, almost 195 million visits were made to hospital outpatient departments, of which 34 percent were made to emergency services. Between 1953 and 1973, outpatient visits increased at the rate of 7 percent per year, and emergency room visits grew at a 10 percent annual rate. American Medical Association, *Profile of Medical Practice, 1975-1976,* pp. 28-29. In 1974, physicians as a whole saw 126 patients per week; general practitioners averaged 174 patient visits per week. *Ibid.,* p. 119.

[13]Eliot Freidson, *Profession of Medicine* (New York: Dodd, Mead & Co., 1971), chap. 5.

[14]*Ibid.*

[15]Mechanic, *op. cit.,* p. 70.

[16]Marian O. Rivkin and Patricia J. Bush, "The Satisfaction Continuum in Health Care: Consumers and Providers Preferences," in Selma J. Mushkin, ed., *Consumer Incentives for Health Care* (New York: Prodist, 1974), p. 312; Lawrence S. Linn, "Factors Associated with Patient Evaluation of Health Care," *Health and Society,* Fall, 1975, p. 533.

far they have shown little tendency to make effective use of such practitioners.[17]

One form of medical practice, the Health Maintenance Organization (HMO), offers physicians greater incentives to change their methods of practice. Although HMO's vary greatly in size and type of organization, they have two basic characteristics: fixed prepayment on a regular basis by subscribers and the assumption by the provider of responsibility for a comprehensive range of services. A number of studies have shown that comprehensive patient care is usually provided at one-third to one-half less cost under the HMO framework compared with other alternatives. Although some HMO's make greater use of preventive services, automated equipment and non-physician personnel, the major reason for the lower cost is the provision of more care on an ambulatory basis and less use of hospitals. Given the lower cost for more comprehensive coverage, some consumers prefer this option to other forms of health insurance. Satisfaction with the program tends to increase over time.[18]

TREATMENT OF COMMON MEDICAL PROBLEMS

Perhaps the major discrepancy between the needs of patients and the kinds of medical care available is illustrated by the sort of problems for which the services of a physician are most commonly sought. These include upper respiratory infections, mild to moderate psychiatric and psychosocial problems, simple injuries, skin problems, allergies, a variety of other infections, hypertension, ulcers, asthma, malignancies, arthritis, diabetes mellitus, and obesity. Among young children a large proportion of visits to doctors are made for health check-ups and immunizations.[19]

Many of these problems are self-limiting in nature and/or are problems about which most doctors feel they can do very little. Others are chronic problems requiring routine management for the most part. Clearly, first contact medical care requires good diagnostic competence that leads to an early recognition of serious problems, but it also requires a broad view of problems and interest in patients and their concerns. At present, training directed to producing physicians capable of performing these functions is largely limited to family practice residencies. Patients with common, minor ailments, especially those with psychological problems, are likely to receive inappropriate care and may even be perceived as nuisances by a busy physician. The authors of one study of a primary care practice concluded that 40 to 50 percent of the work being done could be transferred to less highly trained health personnel working in a team arrangement with physicians.[20]

FRAGMENTATION OF PATIENT CARE

The other major problem associated with the trend toward specialization in medicine is the fragmentation and depersonalization of patient care. With the increasing scarcity of primary care practitioners, individuals at all economic levels frequently have no personal physician or regular source of medical care to which they turn first when a problem arises. The lack of continuity between doctors (or health care providers) and patients is detrimental both to the physician's understanding of the patient's problems and to the sense of satisfaction which both are likely to have with the relationship. Symptoms can be better understood if a patient's history and way of life are known and, given the time constraints under which most medical care is provided, this is likely only when a continuing relationship develops. Continuity also greatly increases the potential for communication and understanding between doctor and patient, factors closely related to patient satisfaction and willingness to comply with the recommended treatment. Finally, a regular source of medical care is related to seeking treatment promptly when symptoms develop.[21]

Whether medical care is received from a number of different specialists, as is common among patients from higher income levels, or from a combination of private practitioners, outpatient clinics and emergency services, as is more common among lower income house-

(*Continued on page 32*)

[17]Uwe E. Reinhardt, "Proposed Changes in the Organization of Health Care Delivery: An Overview and Critique," *Health and Society,* Spring, 1973, pp. 196-197.

[18]Milton I. Roemer and William Shonick, "HMO Performance: The Recent Evidence," *Health and Society,* Summer, 1973, pp. 295-300, Rivkin and Bush, *op. cit.,* pp. 313-315.

[19]"The National Ambulatory Medical Care Survey: 1973 Summary," *Public Health Reports,* May-June, 1976, p. 293; Samuel Wolfe and Robin F. Badgley, "The Family Doctor 1960-2000 A.D.," *Medical Care,* September-October, 1973, pp. 364-366.

[20]*Ibid.,* p. 364; Mechanic, *op. cit.,* pp. 69-70.

[21]Linn, *op. cit.,* pp. 541-546; Marshall H. Becker, Robert H. Drachman, and John P. Kirscht, "A Field Experiment to Evaluate Various Outcomes of Continuity of Physician Care," *American Journal of Public Health,* November, 1974, pp. 1062-1063; Richard J. Gross, "Primary Health Care: A Review of the Literature through 1972," *Medical Care,* August, 1974, p. 642; Julius A. Roth, "Utilization of the Hospital Emergency Department," *Journal of Health and Social Behavior,* December, 1971, p. 314; Lu Ann Aday, "The Impact of Health Policy on Access to Medical Care," *Health and Society,* Spring, 1976, p. 219.

Mary W. Herman is the author of "The Poor: Their Medical Needs and the Health Services Available to Them," *Annals of the American Academy of Political and Social Science,* January, 1972, and "Health Services for the Poor and Neighborhood Health Centers," *Hospital Administration,* Spring, 1972. Since 1974, she has been associated with the Office of Medical Education, developing educational objectives and teaching social aspects of medicine.

"As long as scientific medicine is regarded as the primary factor in health care, rising costs and life-and-death decisions are inevitable," notes this critic, who believes that "It is perhaps still possible to establish a flexible system that would permit people to realize their right to health care in ways that correspond to their own needs, beliefs and conditions, rather than those of the medical professions, the hospitals and the pharmaceutical and medical equipment industries."

The Right to Health Care

By Benjamin B. Page
Assistant Professor of Philosophy and Health Services Administration, Quinnipiac College

THERE is considerable debate in the United States today over the proposition that health care is or should be considered a right. Almost every word in this proposition calls for exploration.

To begin with, there is the question of the nature and source of rights. The concept that something is or should be regarded as a right is a tool often used by those seeking to justify social change or those trying to preserve existing prerogatives in the face of efforts for change.

Both groups are active in the case of health care. On one side are the growing number of interests and groups concerned about the increasing costs of health care and the inequalities and injustices that exist in its delivery. On the other are segments of the health care professions concerned that making health care a right would require them to practice in specialties, localities, or situations not of their own choosing. The right to health care for all, they believe, would infringe on the health care providers' rights to free choice of how they earn their livelihoods.

Thus, in a widely read article in the *New England Journal of Medicine,* Dr. Robert W. Sade attempts to refute the proposition that health care is a right.[1] Other health care professionals acknowledge that there are injustices and inequalities in our society, many with a negative effect on health. But, they ask, why should the medical profession bear the brunt of efforts to correct or compensate for society's ills? Physicians are no more responsible than other elements of our society. Unless the rest of society is also to be mobilized, it is unfair, say such voices, to single out physicians as the profession whose individual rights are to be sacrificed.

Those who regard health care as a fundamental right and favor immediate action to make it available to all are presumably willing to accept infringement on provider rights as part of the "price" to be paid in the process. They must face a further question about the rights of care providers who would be asked to pay this price. Would physicians have the right to organize to defend their interests, perhaps even to strike, like other groups of public servants? Or is health care so basic that such provider rights would be circumscribed?

Those who stress the priority of provider rights are more likely to urge moving slowly, perhaps through the use of incentives and the like to entice providers "freely" to select needed specialties or localities. This is more in keeping with our national traditions and institutions, but it also involves a price: it means asking those now deprived in terms of access to health care to wait a while longer, in the hope that the incentives will "work."

Discussion must also focus on what is it that would be established as a right—what is health care? There is a general tendency to identify health care with medical care. Our fee-for-service system of private enterprise medicine has provided *medical* treatment to those able to pay or who are covered by appropriate insurance. To this extent "health care" has never not been a right, and those so far left out are increasingly being covered by welfare programs, Medicare, Medicaid, and the like. If this is what is meant by health care, perhaps all that is needed is the improvement of welfare coverage and mechanisms. With the guarantee of a fee for treating even the poorest patients, physicians and medical facilities might establish themselves in previously underserved poverty areas. Thus medical care would gradu-

[1]Robert W. Sade, "Medical Care as a Right: A Refutation," *New England Journal of Medicine,* vol. 285 (December 2, 1971), pp. 1288-1292. See also the attempt to refute such thinking by Benjamin B. Page, "Who 'Owns' the Professions?" *Hastings Center Report,* vol. 5 (October, 1975), pp. 7-8.

ally become available to almost everyone, on a basis profitable to the providers of care and to their back-up in the drug and medical equipment companies. Those who could pay for it, or whose insurance could pay, would continue to be responsible themselves for health care; those who could not would become the responsibility of society through the tax and welfare systems. And all this could be accomplished with minimal government interference in the medical care system itself.

This approach raises little conflict with our established economic institutions. However, while it might entice providers to practice in heretofore underserved urban areas—as it already has, sometimes to the accompaniment of cries of "scandal" when a physician seems to be getting too rich from such practice—it would by itself do little for sparsely populated rural areas. Nor would it persuade physicians to select socially needed specialties instead of professionally interesting, prestigious or lucrative ones. Most important, it would do nothing about the problem of the costs of medical care.

RISING MEDICAL COSTS

This issue has led to a continuing debate over the financing and organization of the delivery of medical care. This debate actually began during World War I, when medical examinations for military service revealed a disturbingly large percentage of United States youth to be unfit for medical reasons, most of which could have been prevented had adequate access to adequate care been available. The Soviet revolution, the "Roaring Twenties," the Great Depression, and World War II all intervened to overshadow the problem, even though medical examinations for military service in the 1940's showed results similar to the results two and a half decades earlier.[2]

During World War II, large numbers of servicemen and their immediate families received their first exposure to more or less regular medical care, care that was delivered under economic conditions akin to those of socialized medicine. Because of this experience, there was a strong movement after the war to nationalize medical care delivery. This movement was effectively blocked by the American Medical Association and allied interests. The upshot was the enactment of programs providing federal support for hospital construction and modernization; massive federal support for medical research (which has been responsible for the superiority of the United States in terms of technological sophistication); and the rapid expansion of private and group-based medical insurance.[3] Because of the threat of civil violence characteristic of the early 1960's, the administration of President Lyndon Johnson enacted several programs to improve the economic and geographical availability of medical care to minority groups and the aged.

None of these programs, however, helped to check the rising trend of medical costs, a trend caused by two factors, deeply embedded in our health care system. One of these is the fee-for-service system. It does not matter what the source of the fees is—private patients, insurance companies, or federal programs. Most providers derive most of their income from the delivery of medical care to people suffering from illness or injury. So long as this is true, neither the providers, the hospitals and the nursing homes, nor their backup in the pharmaceutical and medical equipment industries have any *objective economic* interest in the prevention of disease or accident or in the promotion of healthful living and working conditions.[4] In fact, the branch of medicine that deals with these issues, public health, has traditionally enjoyed far less prestige and income than have those who treat the victims of disease or accident in the eyes of the general public and within the profession.

It is worth noting, in this regard, that the pharmaceutical and medical equipment industries have long been among the most profitable in our economy. A special issue of *Fortune* devoted to the "health care crisis" mentioned them as major potential growth industries and hence as very good investments.[5]

EXPENSIVE TECHNOLOGY

The other even more basic factor in the rising costs of medical care is the assumption that health care is equivalent to medical care, that technologically sophisticated, scientifically oriented medical care is the basis of modern health care. As in most areas, technological innovation and scientific discovery are highly costly in and of themselves. In addition, in medicine, their application increases instead of reducing other costs. Each new procedure for diagnosis, treatment, or rehabilitation requires new capital outlays and sometimes new construction, and new categories of personnel, while it only occasionally eliminates the need for older procedures. Facilities and teachers to train new personnel must be provided; the newly trained specialists then command higher pay. Subsequent competition among providers, hospitals and nursing homes for "modernity"

[2]Iago Goldstone, *Medicine in Transition* (Chicago: The University of Chicago Press, 1965), esp. ch. 1. See also the Report of the Commission on the Costs of Medical Care of the American Public Health Association in 1932. Its recommendations are intriguingly similar to those of the original version of Senator Edward Kennedy's national health insurance proposal, somewhat weakened since.

[3]See Richard Wertz, "Introduction," in Wertz, ed., *Readings on Ethical and Social Issues in Biomedicine* (Englewood Cliffs, N.J.: Prentice Hall, 1973).

[4]Two other factors peculiar to the U.S. that have further influenced the rise of medical costs in this country are our pattern of reimbursing patients or providers through insurances primarily for services delivered in hospitals, nursing homes or emergency rooms, and our rapidly rising rate of medical malpractice suits.

[5]*Fortune,* January, 1970.

means that they purchase the latest equipment even if their old equipment is adequate or when there is little effective need for the new equipment.

The more technologically sophisticated but highly expensive means of diagnosis, treatment, and rehabilitation for more and more problems defined as medical problems are developed, the more the costs of medical care will rise. Costs will continue to rise if we assume that medical care is the way to realize health care as a right for all citizens, whether individual patients, insurance programs, or the state pay the bills. The Marxist countries and other countries with socialized medicine also face the problem of cost escalation.

SOME PROBLEMS

Thus those who urge health care as a right and assume that making modern, scientific medical care available to all is the way to implement this right face crucial choices. As biologist-philosopher René Dubos has pointed out, no society can make a commitment to providing modern medical care to all its citizens who need it without feeling the effects of that commitment in other areas. If modern medical care is provided to everyone, there will be little public money left for other socially valuable programs, in the fields of education, culture, defense, or whatever.[6] Alternatively, as has already begun to happen in Sweden and England, tax rates will be so high that individuals have little money to spend as they choose. Can any society make such sacrifices, even in the name of "health care," and still remain viable and able to grow in other areas?

Another possible course—no less problematical—has been forecast by medical economist Victor Fuchs. Society may have to accept the fact that medical facilities, technologies, personnel, and services will always be in short supply. Choices will then have to be made about which technologies should be developed, and who will have access to scarce medical resources.[7] Who should make such decisions—literally decisions of life and death—and on the basis of what criteria? How should the criteria be established? Such questions already face the committees that must decide which patients will have priority access to life-sustaining therapies like kidney dialysis. The extension to other life and death situations is a logical consequence of adherence to the medical model of health care, unless we are willing to accept the first alternative and curtail personal and public expenditure in other areas.

In addition to the questions of costs and choices, the medical model of health can be challenged in at least one other important area. Medicine as traditionally practiced in the United States has little influence on the familial, job-related, socioeconomic, cultural and other conditions that so frequently lead a person to become a patient.[8] Nor can a person do much about his working and living conditions, however dangerous to his health they may be, unless he has the economic and educational mobility to move or change jobs. Because many of our illnesses and injuries are closely related to the ways we earn, live, and eat, at best medicine deals primarily with symptoms and effects.

Ultimately, the question should be raised as to whether, even with the best of medical care, one can be healthy in a society that itself is unhealthy or fosters ill health or a high risk of injury. Is the health of one who works in a highly competitive or stressful job protected when medicine supplies a chemical agent that helps that person survive? Can a society in which increasing numbers of people turn to addictions and/or crime, while others live in fear of victimization, be considered healthful? Can many people maintain a healthful diet in a society whose food processors and grocers find it most profitable to advertise and sell junk foods or foods stocked with additives, preservatives, or hormones? The number of questions grow almost daily. Medical ways of responding grow almost as fast, but does that mean that health care is improving?

Clearly, a serious commitment to health care might carry us further into questions about our economic and sociocultural institutions than most people want to go, as those working in the field of public health have long known.[9] After all, these same institutions are responsible for the very high standard of living enjoyed by most Americans, even the poorest.

Thus we are brought almost full circle. Substantive interference with these institutions, even in the name of health, would inevitably involve the infringement of existing rights and changes in established values. The long-term outcome of substantive change might be a vastly healthier population. Is this possibility a sufficient base from which to justify the interference?

ALTERNATIVE MODELS

Because of the problems associated with the medical model of health care, it is important to consider alterna-

[6] René Dubos, *Man, Medicine, and Environment* (New York: Praeger, 1968).

[7] The title of Fuch's book is apt: *Who Shall Live? Health, Economics and Social Change* (New York: Basic Books, 1974). See also Leon Kass, "The New Biology: What Price Relieving Man's Estate?" *Science,* vol. 174 (November 19, 1971), pp. 779-788.

[8] The Health Maintenance Organization concept was developed in part in the hope of encouraging greater interest among both providers and patients in preventive medicine. However, even if this hope were maximally realized in most of the some 200 operating HMO's, it is still limited to preventive medicine on the purely personal level.

[9] People in public health in many countries have traditionally been more socially and politically progressive than their other medical colleagues. See for example the large number of articles devoted by the *American Journal of Public Health* to social, political, and economic aspects of health and health care delivery during the 1960's, or the APHA's 1932 report on the Costs of Medical Care, mentioned earlier. For an international perspective, see Kenneth W. Newell, ed., *Health By the People* (Geneva: World Health Organization, 1975).

tives.[10] The medicine we know today—which regards medicine as an empirical, natural science, considers disease as an instrumentally verifiable deviation from statistically established norms, and sees human beings in terms of organ systems, biochemical processes, diseases or injuries—is less than a century old.[11] Moreover, it was established at a time when it could demonstrate little scientific superiority over available alternatives and it did so in what was largely a political process.[12]

From this follow two questions. It is often asserted or assumed that the vast array of scientific breakthroughs, miracle cures and lifesaving technologies of scientific medicine are proof of its superiority to all other approaches to problems of illness or injury; scientific medicine is even regarded as the *only* valid approach to illness.[13] However, there is room to wonder whether any other approach, if it had enjoyed the "official" status of scientific medicine and the large amounts of public, corporate and private money poured into research based on it, might not have achieved results that were qualitatively as impressive.

[10]In "The WHO Definition of Health" Daniel Callahan raises the possibility that if we accept the WHO definition of health and assume the medical profession to be the purveyor of health, we might end up with a medical authoritarianism. See *Hastings Center Studies,* special issue on "The Concept of Health," no. 3, 1973. See also B. and J. Ehrenreich, "Health Care and Social Control," *Social Policy,* vol. 5 (May/June, 1974). In "Science: Limits and Prohibitions" *Hastings Center Report,* vol. 3 (November, 1973) and *The Tyranny of Survival* (New York: Macmillan, 1973), Callahan argues for the development of a "science of limits" in the use of technology. See also "Les limites de la medicine" (Geneva: Centre d'Etudes Protestantes, 1974).

[11]See e.g., Henry E. Sigerist, *A History of Medicine,* 2 vols. (New York: Oxford University Press, 1951 and 1961).

[12]See Rosemary Stevens, *American Medicine and the Public Interest,* part 1 (New Haven: Yale University Press, 1971).

[13]The uncritical commitment to the unique validity of the scientific model of medicine as crucial to realization of the right to health care is particularly strong in the socialist countries. There, however, the development of preventive medicine and efforts to promote healthful living and working environments are also more strongly based than in the U.S. See e.g., Czechoslovakia's 1966 *Law on the Health Care of the People.* English version published by the Czechoslovak Ministry of Health, Prague, 1966.

[14]The symposia, etc. were held respectively: at Harvard Alumni College, June, 1975; under the auspices of the Institute for the Study of Human Knowledge, in cooperation with Albert Einstein College of Medicine, in New York, Spring, 1975, 1976, and 1977; and through the Boston Family Institute, April, 1977. They are of course merely illustrative of the kinds of things going on and by no means a definitive list of such events.

[15]See e.g., Lowell Levin, Alfred H. Katz, and Eric Holst, eds., *Self Care: Lay Initiatives in Health* (New York: Prodist, 1976), or the new journal, *Medical Self Care.*

[16]A problem of growing proportions in this regard is that of iatrogenic disease, disease caused by efforts to treat patients for other conditions. See e.g., P. F. D'Arcy and J. P. Griffin, *Iatrogenic Diseases* (London: Oxford University Press, 1972).

The second question is to what extent is it true that scientific medicine "works" for us because, in our scientifically and technologically oriented culture, we *expect* it to work. This is not to suggest that there is no objective foundation to scientific medicine. Nonetheless, most conditions that take people to doctors' offices are conditions that the body itself will eventually heal, or which will result in eventual death regardless of medical interventions. The most medicine does in such cases is to reduce anxiety, pain, and the likelihood of infection, so that the body's self-healing capacities can function unhindered by these secondary conditions. The "primitive" folk healer of China, Ghana, or Bolivia does this no less than the modern European or American physician—and neither group is always successful.

In addition, medical anthropologists are beginning to conclude that the feature most common to all forms of medicine and most crucial in the degree of success achieved is belief. If belief is such a crucial factor in the efficacy of medicine in other cultures, why should scientific medicine be an exception? To be sure, the expectations created by beliefs and the values underlying them vary from culture to culture. But on what grounds could those of one culture be considered more valid than or superior to those of another? Moreover, within our own culture there are documented examples of people who either rejected scientific medicine or whose condition remained unaltered by it, and who have nonetheless experienced apparently miraculous recovery on the basis of belief.

This suggests that considerable insight might be gained from the study of alternatives to scientific medicine. In fact, such work has already begun: conferences, symposia, and workshops have been held over the past few years on such topics as "The Crisis of Values in Science and Medicine," "Health and Healing: Ancient and Modern, Eastern and Western," or "New Boundaries for Health: Self, Family, and Society";[14] initially under the impetus of the women's movement, publications and efforts are dealing with the various dimensions of self-care;[15] and more and more articles raise critical questions about hospitalization and medicalization.[16] The benefits of childbirth at home or home care for heart attack victims are being studied. The purpose of such exploration is not to eliminate scientific medicine but rather to reconsider the assumption that it represents the only means or always the most appropriate means of health care, and to discover its valid place in the total spectrum of health care. As long as scientific medicine is regarded as the primary factor in

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Benjamin B. Page recently spent a year in Prague, where he studied the influence of marxism and socialism on the organization of health care delivery and ethical issues in the field.

"For the most part, the role of health insurance will continue to be the protection of those who are sick and injured; but clearly the future roles of the health professions and the health insurance industry will include active concern for keeping people well."

Voluntary Health Insurance

By Walter J. McNerney
President, Blue Cross Association

FOR the past half dozen years, at least, the nation has been engaged in a continuing debate about national health insurance. Physicians and health administrators, legislators and government officials, business executives and labor leaders, professors and journalists have taken positions for or against one or another of the many national health insurance proposals that have been advanced.

At times, interest in the subject has peaked, and enactment of some further health benefit entitlement legislation has seemed imminent. At other times, public interest has appeared to subside, and the debate has degenerated into disputes among the interested parties about details of cost, benefits, populations to be included, and methods of administration. But at no time has the issue been forgotten; no major candidate for public office has refused to take a position, and it is doubtful that anyone who reads the newspapers or listens to news broadcasts is unaware that some kind of health program for the nation has been under consideration. Yet despite so much activity for so many years, so much pressure from so many groups, so many bills written and submitted, and so many hearings conducted, no plan has yet been approved by a committee of the Congress nor has any plan been considered by either the Senate or the House of Representatives. Why not?

One reason, certainly, is that with so many interested groups, with so many divergent views, formidable details must be resolved before any kind of consensus can be reached. Another reason is uncertainty about costs; it is probable that any plan will cost more than its proponents have estimated, and it is doubtful that the federal budget can afford any substantial addition to its already burdensome health expense. But the doubts and the details could probably have been quickly resolved had there been any widespread, intensive public pressure for a national health insurance plan.

There has been no such pressure, in spite of all the efforts of so many special interest groups. And the underlying reason for the lack of pressure is the fact that 180 million Americans are already covered by a private health insurance industry that is paying $100 million a day in health care bills and is obviously meeting the greater part of the need for health care insurance for the greater part of the population. Everybody understands that the system is imperfect. There are still millions of poor people who are either not eligible for Medicaid or are inadequately protected by it, and many of those with private health insurance are covered for only a fraction of their medical expenses. However, since Medicaid reform is a high priority objective of the new federal administration, and since private insurers are expanding their coverage to correct deficiencies, it seems likely that health care insurance can be found in some combination of private and public resources, without a major new federal entitlement.

The total number of individuals having some form of private health insurance at the end of 1976 was estimated by the industry at 183 million, or approximately 90 percent of the United States population. All these individuals were covered for hospitalization expense, it was reported, and 172 million also had surgical expense protection. The number covered for medical expense as well was slightly lower—165 million—and an estimated 103 million had major medical or so-called "catastrophic" coverage of the rare but widely publicized illnesses that are long-lasting and excessively expensive. Commenting on a report on health insurance issued early in 1977 by the Congressional Budget Office, Director Alice M. Rivlin said that the problem of financing catastrophic health care costs is concentrated heavily among poor or near poor families with incomes of $5,000 to $10,000 a year. "Basic insurance protection for low income families and improved mental health and long-term care protection are the areas with least adequate coverage," she explained. "Additional catastrophic protection for middle-income families

would largely duplicate existing private insurance coverage."

The industry that has thus blanketed the nation with health insurance, with only a few scattered holes in the blanket, is still less than 50 years old. In the beginning there was only Blue Cross coverage, a not-for-profit hospital service plan, which, with its affiliated Blue Shield Medical service plans, accounts for approximately half of all private health insurance coverage in 1977. Several hundred insurance companies account for most of the other half.

The idea of hospitalization prepayment originated in Texas in 1929, when a group of schoolteachers started paying a few cents a month to a hospital in Dallas that agreed to furnish needed services to members without further charge. In the years that followed, the idea spread rapidly; by the mid-1930's hospitals and employers had joined together in newly organized communitywide and even statewide plans founded on the same simple principle. An inventive hospitalization plan promoter in Minnesota started identifying its services with a blue cross; the symbolism caught on, and soon all the plans were using it. In this and in a variety of other coordinative and organizational activities the plans were aided by a national Blue Cross Commission organized initially by the American Hospital Association (AHA). This commission became independent of the AHA in the early 1960's and was renamed the Blue Cross Association. The Blue Cross Association and its counterpart, the National Association of Blue Shield Plans, provide a wide variety of technical, coordinative and representational services to the plans. These services include a relationship with the federal government as prime contractor for Medicare and as the major underwriter for the Federal Employee Health Benefit Program.

Not long after the Blue Cross movement began, insurance companies began to take notice. The large group life underwriters began to offer hospitalization indemnity to their group life insurance customers. Soon the accident and casualty companies were also devising hospital plans, and in some states new companies specialized in health insurance. It was the Blue Cross concept that interested insurance companies in the field in the first place, but it was the insurance companies that began to add surgical benefits to their hospitalization plans and thus speeded the organization of the Blue Shield medical service plans.

BLUE CROSS VS. INSURANCE

The distinction between the Blue Cross and Blue Shield Plans and insurance has not always been clearly understood, even by employers, government officials, and others who may have occasion to evaluate health insurance. Blue Cross Plans contract with their subscribers to furnish certain specified hospital services when they are needed; at the time of hospitalization the subscriber pays only for services *not* included in the contract, like an expensive private room, telephone and television service, or an occasional exotic procedure or medication. The plan contracts separately with its member hospitals to pay for the contracted subscriber services at an agreed rate. In the case of Blue Shield Plans, the arrangement is similar, with member physicians as the contracting providers of service.

In contrast, the typical health insurance policy offers the policyholder indemnification or compensation, in stated dollar amounts, for hospital or medical expenses incurred under the stated conditions. In short, the Blue Cross and Blue Shield Plans pay off in hospital and medical services, the insurance companies in dollars.

There are other differences. Blue Cross and Blue Shield Plans are not-for-profit corporations governed by boards of directors consisting, in the case of Blue Cross Plans, of a majority of community or public representatives, with some hospital and physician members, and, in the case of Blue Shield, a majority of physician members. There are 69 Blue Cross Plans in the United States and one in Puerto Rico; nearly all are closely allied with companion Blue Shield Plans. In many areas the plans are merged in a single corporation with one board of governors; in others there are separate corporations and boards but unified management. Where separate managements exist, they usually are closely allied, functionally and geographically. In addition to the service contract, under which most Blue Cross Plan subscribers pay only for services not included in the contract (whereas the commercially insured policyholder must also make up the difference between the hospital's established charges and the indemnities paid by the insurance company), Blue Cross and Blue Shield Plan subscribers have another advantage: if a subscriber leaves the group through which he was enrolled, he may continue coverage with the plan as an individual or non-group subscriber. Other group insurance policies usually have no comparable conversion privilege.

Another advantage enjoyed by Blue Cross and Blue Shield Plan subscribers is that their coverage is never cancelled because of the high use of benefits. Nonprofit plans and insurance company plans alike have many levels of coverage. Rates vary widely by type of coverage chosen and by region, and groups may also be "experience rated"—that is, rates may be adjusted up or down according to whether the group uses more or less than the anticipated volume of hospital and medical services. Thus there is no such thing as an average rate or amount families pay for their health insurance.

However, as Mark Twain once said of Wagner's music, it isn't as bad as it sounds. Everybody understands that the costs of hospital and medical services have been rising steeply for a number of years; obviously, the costs of health insurance have also been rising. But the burden on most families has been eased con-

siderably by the fact that ever since World War II it has been common practice for employers to pay all or part of the cost of health insurance for their employees, especially in many large industries, where employers' payments for health benefits are negotiated in collective bargaining and written into management-labor contracts. Furthermore, the Internal Revenue Service does not consider the employer's contribution to be taxable as part of the employee's compensation. Thus it is employers, unions and insurers who are most exercised about the rising cost of health care and are most determined to do something about it.

In fact, many economists believe that the success of private insurance is at least partly responsible for the continuing increase in health care expenditures. People are so well protected by the insurance system, it is argued, that there is no cost restraint either on the patient seeking services or on the physician ordering them. "The insurance will cover it," a common attitude, may be an invitation to use, and sometimes overuse, expensive services. Certainly physicians have tended to order "everything in the book" for their patients in recent years as a defense against the rising threat of malpractice suits. It is also true that insurance coverage has emphasized hospital services rather than less expensive, out-of-hospital medical services, and thus has perhaps encouraged the overuse of high cost facilities.

But this emphasis has been changing. In recent years, Blue Cross Plans have added and expanded their coverage of outpatient services. In 1976, the plans paid more than twice as many outpatient as inpatient claims. Moreover, experience suggests that changing the benefit patterns to add deductibles and co-payment restrictions that require the patient to pay a larger share of the bill creates a fundamental quandary; when these cost-sharing mechanisms are set at a level sufficient to restrain the utilization of services, necessary as well as unnecessary services are foregone. A delay in seeking needed care can eventually result in the need for more services, thus subverting the original intent of the cost-sharing.

HMO's

Other measures aimed at containing cost will probably be more successful, and many of these measures are being actively pursued by insurers, industry, government agencies and provider groups. The spread of insurance benefits to encourage the use of lower-cost alternatives to hospitalization is one alternative. Interest in prepaid group practices or health maintenance organizations (HMO's), offering comprehensive medical services to defined population groups, is also growing. The best known and most successful HMO is the Kaiser-Permanente Health Plan, whose groups of physicians and institutions offer complete health care services to 2.5 million people in the Western states. With all services paid for in advance (at rates generally comparable to the most comprehensive Blue Cross and Blue Shield Plans), Kaiser experience has indicated that hospital admission rates for HMO subscribers are lower than those for comparable population groups with traditionally organized medical services. The federal government has been offering assistance to HMO's for several years in an effort to stimulate the growth of what appears to be a more economical mode of delivery of health services. Blue Cross Plans are now operating or helping HMO's get started in their communities. The plans are involved in more than 100 HMO's and will continue to support this effort. Growth has been slow, because many physicians are reluctant to leave the familiar pathways of fee-for-service private practice for a system that they regard as an infringement of their independence, and because federal requirements for broad and expensive coverage for government-qualified HMO subscribers have led to marketing difficulties.

Another method of cost containment being supported by the government and by the Blue Cross organization is a change in the method of reimbursing provider institutions. In the past, Medicare, Medicaid and Blue Cross Plans have reimbursed hospitals and other health care institutions for services delivered to eligible beneficiaries and subscribers in accordance with payment formulas based on the costs of the services. This method obviously offers no particular incentive to the institution to control the cost of its services. Today, both the government and the Blue Cross Plans are experimenting with prospective reimbursement, negotiating rates for various services in advance so that institutions may share in any savings that can be effected but are penalized if costs exceed the negotiated rate. No one satisfactory system of prospective payment has yet emerged, but one plan that has completed a year's experiment has reported lower costs in hospitals that participated in the prospective payment experiment than in those that did not. It seems likely that if these results are repeated, more plans and programs will switch to the incentive method.

HSA's

Two more broad efforts to contain health care costs are planning and utilization review. Planning is now mandated by Public Law 93-641, the National Health Planning and Resources Development Act, creating a network of Health Systems Agencies (HSA's) under state jurisdictions with authority to review and approve or disapprove institutional plans for addition, expansion, or other major changes in facilities or services. The law was born out of the conviction in Congress that the surplus of hospital beds and the duplication of expensive, high-technology facilities and services (like those required for heart surgery and extensive radiologic examinations) have added unnecessarily to the cost of care for everybody, and that voluntary efforts at regional

planning have been unsuccessful in curbing these practices. The new HSA's are controlled by community boards that must have a majority of consumer members. This provision of the law aimed at preventing self-serving decisions by provider members has been opposed and, in fact, challenged in court by providers. They charge that lay persons have been given too much authority to make decisions that may obstruct a physician's right to practice medicine as he sees fit.

The HSA's are just starting to review plans, but already there is evidence of their restraining influence on expansion and the redundancy of facilities. The HSA's have also speeded the rate at which institutions are cooperating to share services, coordinate plans and undertake joint activities. A recent study identified some 2,000 hospitals that belong to some form of multi-unit system; the systems range from chains under common ownership to contracts or agreements for sharing services. It seems inevitable that this trend will continue. The free-standing hospital unlinked by any kind of arrangement with neighboring institutions may shortly become a rarity, and the effect on the total health economy is bound to be wholesome. Blue Cross Plans have taken part in this movement by offering services like data processing, accounting and methods engineering for joint use by member hospitals.

Blue Cross Plans have also provided assistance to hospitals in strengthening their utilization review (UR) activities. Hospitals participating in Medicare are required to have UR committees made up of medical staff members who review medical records to identify lapses in good practice, like overlong stays, unnecessary admissions or operations, inappropriate medications or services, and other departures from accepted standards. Theoretically, errors and aberrations are called to the attention of the offending physicians, who are thereby encouraged to mend their ways, with resulting improvement in the quality and economy of patient care. However, UR has not always worked well. Physicians are notably shy about critizing or questioning their friends and colleagues. And the question that is raised weeks or months after a patient has been discharged, as is commonly the case in a retrospective review of records, lacks force and focus and is not very effective as a means of education.

The federal government has finally moved to make UR more effective. The Social Security Amendments of 1972 included a provision setting up a system of Professional Standards Review Organizations (PSRO's). These independent bodies of physicians are responsible for establishing standards and for conducting or supervising utilization review to make certain that the care of government-funded patients (chiefly Medicare and Medicaid) is provided in accordance with established standards. PSRO areas correspond roughly to HSA areas, and it is expected that there may be a useful exchange of utilization data between the two bodies. A hospital committee may still review Medicare and Medicaid patients, but the committee must satisfy the PSRO that the review takes place promptly (in most cases while the patient is still in the hospital) and effectively.

PSRO's have taken even longer to organize than HSA's. Five years after the act was passed, PSRO's were actually reviewing the care of Medicare and Medicaid patients in only a little more than half the 203 PSRO-designated areas; in areas where physician opposition to the plan has been widespread and forceful, little if anything has been accomplished. As a rule, physicians do not take kindly to being told what to do, especially by government, and it is by no means certain that the system will accomplish the quality and economy objectives Congress had in mind.

For this reason, there has been a growing belief in government circles that the only effective way to slow the rise in the cost of medical care is to set a firm ceiling on what can be spent for care—not just by government but by private payers as well. Thus Congress has under consideration a proposal by the administration to limit any increase in payments to hospitals to 9 or 10 percent a year; similar controls on physicians' fees may also be considered. There is sure to be powerful opposition to any such proposal, as there has been to the proposed lid on hospital costs. It remains to be seen whether such a maneuver will be authorized by Congress and, if it is, whether it will be effective in slowing the cost increase without damaging the availability and quality of care.

Whatever measures are adopted to check the rising costs of medical care, however, there is a growing conviction in the health professions, in industry and in government that pouring more billions of dollars into health care will not contribute significantly to the improvement of the population's health unless a national effort is directed toward preventive measures, toward teaching and persuading people to take more responsibility for their own health and toward eliminating the occupational and environmental hazards that cause illness and disability. President Jimmy Carter has said:

> We must return to the basic focus on the prevention of illness and disease, including a strong neighborhood and community orientation; we must stress health and nutrition education; and we must mount a renewed attack on cancer and other diseases caused by toxic chemicals in the environment.

And Joseph A. Califano, Jr., the Secretary of Health, Education and Welfare, has explained further:

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Walter J. McNerney is a consultant and author on the health delivery system. He served as president of the National Health Council, chaired the task force on Medicaid and Related Programs for HEW and was vice-chairman of the President's Committee on Health Education.

". . . Health Security is not a panacea. It will not cleanse the environment or improve living conditions and housing. All it will do is make real the principle that the poor, the deprived and the working people of the United States have the same right to health care, and to life itself, as the affluent."

The Case for National Health Insurance

By Max W. Fine
Executive Director, Committee for National Health Insurance

NATIONAL health insurance is an idea whose time has come. Americans have a right to good health care. It is not a privilege to which some should be entitled and others not. It is not a luxury to be rationed according to one's ability to pay. It is not a commodity whose priority of purchase an individual family can determine along with cars, boats, CB radios and stereo sets. When a baby needs care, a mother has no choice. She cannot postpone the health care until next month because she needs the money for a new dress. The baby must be cared for now. When a youth breaks an arm in a pick-up football game, he can't tough it out like Walter Mitty in his secret life. The broken bones must be set. When a pregnant girl needs prenatal care, she can postpone it only at high risk both to herself and to the embryo growing within her.

Health care is not another item in the marketplace to be selected according to choice. The choice is often life or death, lifelong health or illness, prenatal care or mental retardation, preventive and early diagnostic care or unnecessary disability and even worse.

Numerous national surveys show that the American people regard health care as a right, and substantial majorities select national health insurance as the vehicle for the fulfillment of this right. After 40 years of effort, the private health insurance industry has failed to provide universal coverage: nearly 40 million Americans have no health insurance whatsoever; and even for those with coverage, the insurance meets only 40 percent of health care costs. Many millions of others are not covered for necessary services outside of a hospital setting (see chart). Because of the terms and conditions of private health insurance plans and policies, preventive medicine is neither practiced by physicians nor sought by most Americans, and unnecessary hospitalization is common.

Even though its best efforts have failed after 40 years, the private health insurance industry continues to resist national health insurance. It employs a powerful lobby in Washington, D.C., to fight against any national health insurance plan except one of its own design, which would merely subsidize and maintain the present system of financing and delivering health care. But such a plan inevitably fails to measure up to basic principles needed and demanded by the American people. Asked whether the industry subscribes to the principle that a person should have a right to health care, the chief executive of one of the largest health insurance carriers testified: "Of course, as long as he can pay for it."

Every industrialized country in the world, except the United States, already has some form of national health insurance or directly provides health care to its citizens through a national health service. The first to adopt national health insurance was Germany, under Otto von Bismarck in 1883. The most recent was Canada, which in 1968 instituted a nationwide medical care program (for physicians' services) to accompany a universal hospital insurance program adopted 10 years earlier.

Britain and most East European countries operate direct national health services; other developed countries have chosen various types of national health insurance plans. A national health service is not being considered seriously in the United States, although opponents of national health insurance have often smudged the difference with the scare words, "socialized medicine." The most progressive national health insurance bill before the 95th Congress is the Health Security Act sponsored by Senator Edward M. Kennedy (D., Mass.) and Congressman James C. Corman (D., Calif.) along with 80 cosponsors. This bill does not propose to nationalize hospitals and make doctors civil servants, as in a national health service. It does propose to pay for health insurance through increased taxes on employers and out of federal general revenues, while eliminating Blue Cross-Blue Shield and other insurance. But the provision of health care—by hospitals, doctors, and so on—would remain strictly private and not be "socialized."

The United States is able to provide good health care to all its residents. Performance has not matched capa-

bility or expenditures. The United States is already spending more than other countries with universal health care systems—more per capita and more as a percentage of gross national product. In 1976, the average American worked one month just to pay for medical care and private health insurance costs. We spent an average of $670 in 1976 for every man, woman, and child for personal health care services, three times more than we spent ten years earlier. We spend 8.8 percent of our GNP for health care, and the amount is uncontrolled and constantly rising.

Americans cannot budget and finance all their personal health needs through the existing private payment system. Many must borrow to pay medical bills, and some families each year are driven into bankruptcy due to the costs of illness or injury.

Americans take pride in the great achievements of their medical science and technology. Americans have won more Nobel Prizes in medical research than any other country. In every region of the nation there are outstanding medical centers and physicians and surgeons of great renown.

Yet in 150 counties of the United States there is no physician practicing medicine, and in 250 other counties there is only one. In affluent communities, there may be one doctor for each 200 residents; in poor sections of the same cities, there may be one doctor for 10,000 residents. Illness rates in our inner cities resemble those of backward countries.

With personal health services falling behind the capacity of modern medicine, and the needs of millions of poor, near-poor and working people largely unmet, the United States is paying a high price to subsidize private health insurance carriers who, in turn, maintain a wasteful, inefficient, ineffective and semifunctional health care delivery system.

Patients cannot persuade doctors to make house calls, even in emergencies. Often, appointments to see a physician in his own office must be made weeks in advance. Once in the outer office, patients learn why it is called a "waiting room"; it is not uncommon to be kept waiting well beyond the fixed appointment time. Family physicians seem to be disappearing in an era of specialization. For millions, the health care delivery system has already broken down.

In an effort to revitalize the system and to overcome serious deficiencies, labor unions, church groups, civil rights organizations and young health professionals have for many years been calling for national health insurance. Their efforts have been opposed by the private health insurance industry and the American Medical Association (AMA). However, the latter has now developed and is supporting a different version of "national health insurance." It is important to differentiate between the national health insurance proposals before the 95th Congress.

The AMA is supporting a bill (H.R. 1818) that would require all employers to offer their full-time, permanent employees a private health insurance plan. The employer would be required to pay at least 65 percent of the premium costs, with employees paying the remainder for themselves and their families. This program would result in improved coverage for many Americans. But the plan would not control the runaway costs of health care, which we have been experiencing for many years. Nor would it produce answers to defects in the methods of organizing and delivering services. The AMA is not asking that the system for financing health care should be left alone, but that the AMA should be left alone. As the AMA sees it, efforts to encourage preventive medicine should not be covered by national health insurance. More doctors should not be trained (the AMA contends we have too many already). There should be no incentives for family health care plans, under which physicians practice in groups to make various specialties available under one roof at a fixed price. Family health care plans have demonstrated that they provide better care and that those who participate require far less hospitalization, but these and other proposed reforms are called "interference" by organized medicine.

For many years, organized medicine has been led by outspoken and articulate leaders. They recognize that competition lies at the heart of a successful free enterprise system. But they have worked diligently to deprive themselves of the benefits of competition. For many years, they opposed federal aid to medical education so that the numbers of places in medical schools were limited and qualified young people were denied the opportunity to enter medical school. They opposed the emergence of new types of health personnel, including nurse practitioners with special training who would be available in areas where no physician was available. They opposed family health care plans, now commonly called "health maintenance organizations," even labeling them as "soviets" because they involved group practice.

The health insurance industry, on the other hand, has insisted that only competition among the many health insurance carriers can control costs. More than 1,200 insurance companies and 70 Blue Cross and Blue Shield plans are all seeking to sell their services to employers and to individuals and families, and health insurance companies contend that this competition will restrain premium increases.

However, experience over many years has shown that competition to sell health insurance policies at the lowest possible premiums does not control hospital and medical costs, but rather guarantees runaway inflation and waste. To keep costs down, the policies are restrictive, often limiting benefits to periods of hospitalization. This results in unnecessary hospitalization in order to obtain "coverage."

Carriers impose deductibles and coinsurance pay-

ments on their "insureds"—the patients—to instill cost consciousness in patients. They fail to control waste in hospitals and ignore the fact that it is the physician, and not the patient, who decides when to hospitalize, when to discharge, what services to order and what medicines to prescribe. Little effort is made to instill cost consciousness in physicians.

COSTS OF HEALTH SECURITY

One myth about national health insurance has served more than any other to weaken the efforts of those supporting reforms and to delay congressional action. This is the myth that it costs too much.

In September, 1970, after two years of development by an expert committee of academicians, reformers introduced a national health insurance bill. Subsequently President Richard M. Nixon told the annual convention of the American Medical Association that the United States could not afford its $57 billion costs. Periodically over the next six years, Presidents Nixon and Gerald Ford decried the costs of the bill, which became known as "Health Security" (H.R. 21). President Ford said it would cost $100 billion.

But actuaries in the Nixon and Ford administrations were reporting that Health Security would not cost much more than was already being spent by the American people in private insurance and tax-paid programs. The figures, confirmed by the Congressional Budget Office, show the following:

> In fiscal year 1976, the American people spent $139.3 billion for health care.[1]
>
> They spent $39.9 billion in federal health programs such as Medicare and Medicaid.[2]
>
> They spent $19 billion as state and local taxpayers for state costs of Medicaid and other public health care programs.[2]
>
> They spent $80.5 billion for Blue Cross-Blue Shield plus other private health insurance premiums plus the deductibles, co-payments, office visits and other costs not covered by the insurance.[3]
>
> Of the $80.5 billion, they paid an estimated $35 billion directly to the insurers who provided the coverage—mainly for hospital-related care.
>
> The insurers retained $7.3 billion for their operating expenses and profits.[4]

Thus, Health Security—even by the $100 billion-plus cost estimates of its opponents—would not cost much more than is now being spent and, over a period of time, would actually reduce costs by billions of dollars per year. Medicare and Medicaid would be eliminated. Taxpayers would be relieved of billions of dollars of expenditures. Payments to Blue Cross and Blue Shield and insurance companies would cease. The billions now retained by the insurers would go for better health care, not operating expenses and profits.

Health Security would combine all expenditures; it would utilize cost control factors by negotiating with doctors and requiring prior approval of hospital budgets, to keep costs down throughout the country.

The funds needed to pay for Health Security would be raised from payroll taxes and federal general revenues rather than from insurance premiums, state and local taxes and out-of-pocket payments, but they would total very little more than is already being spent and they would provide comprehensive coverage for every American.

It is clear that the charge of the high cost of the health security bill was a successful tactic to scare economy-minded congressmen. Even when national surveys and their own district surveys showed a consistent majority support for a health security-type national health insurance plan (see box), congressmen were reluctant to move the proposal through the legislative process for fear of being called spendthrifts by the White House.

President Jimmy Carter has promised to enact a comprehensive national health insurance plan. He described the plan he has in mind in several campaign speeches and reaffirmed his determination in a recent visit to the Department of Health, Education and Welfare. In a detailed presentation to the platform committee of the Democratic party on June 12, 1976, Jimmy Carter said:

> Our present health care system is in need of drastic reorganization. Despite per capita and absolute expenditures on health care that are the largest in the world, our nation still lacks a workable, efficient and fair system of health care.
>
> First, we need a national health insurance program, financed by general tax revenues and employer-employee shared payroll taxes, which is universal and mandatory. Such a program must reduce barriers to preventive care, provide for uniform standards and reforms in the health care delivery system, and assure freedom of choice in the selection of physicians and treatment centers.
>
> We must shift our emphasis in both private and public health care away from hospitalization and acute-care services to preventive medicine and the early detection of the major cripplers and killers of the American people. . . .

In 1977, President Carter directed the Department of Health, Education and Welfare to develop for enactment in the current Congress a comprehensive national health insurance plan that could be phased in over a period of four to five years.

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[1] U.S. Department of Health, Education and Welfare (HEW), Office of Research and Statistics Note, no. 21, December 22, 1976.

[2] *Ibid.*, Table 2. National health expenditures by type of expenditure and source of funds, fiscal years 1974 through 1976 (federal, state and local).

[3] *Social Security Bulletin,* vol. 39, no. 2 (February, 1976), p. 6, Table 1. Aggregate and per capita national health expenditures, by source of funds and percent of gross national product, selected fiscal years, 1929-1976.

[4] *Social Security Bulletin,* vol. 39, no. 2 (February, 1976), p. 7, Table 2. $7.3 billion total ($5.7 billion private business; $1.6 billion as government agents).

SURVEYS ON NHI

April, 1974—Louis Harris National Survey

"It has been proposed that Congress pass a comprehensive health insurance program which would combine federal government, employer and employee contributions into one federal health insurance system that would cover all medical and health expenses. Opponents say that would get the federal government too much into medicine and health care. Supporters say such insurance is necessary for people to obtain proper coverage. Do you favor or oppose such a comprehensive federal health insurance program?"

FAVOR	54%
OPPOSE	28%
NOT SURE	18%

January 4, 1976—NBC News Poll

"Do you favor or oppose a national program of health insurance with the government paying part of the cost?"

FAVOR	63%
OPPOSE	29%
NOT SURE	8%

September 6, 1976—*Time* Magazine

"Do you favor a comprehensive national health bill?"

YES	61%
NO	23%

Spring, 1975—Cambridge Survey

"Would you agree or disagree? I would be willing to have my taxes raised if the money was spent on a national health care system that guaranteed each person as much health care as he or she needs."

AGREE	66%
DISAGREE	26%
DON'T KNOW	8%

THE "QUALITY" OF PRIVATE HEALTH INSURANCE

The population under age 65 totaled 188,467,000 persons on January 1, 1975. The population aged 65 and over totaled 22,126,000 at that time.

- 20.1%—37,882,000 people—under age 65 had no hospital insurance.
- 21.7%—40,897,000 people—under age 65 had no surgical insurance.
- 26.4%—55,571,000 people—of all age groups had no insurance for in-hospital visits.
- 27.3%—57,576,000 people—had no insurance to cover X-ray and laboratory examinations when out of the hospital.
- 40.6%—85,410,000 people—had no insurance for visits to doctors' offices or doctor visits to their homes.
- 32.7%—68,838,000 people—had no insurance against the cost of prescribed drugs.
- 84.2%—177,296,000 people—had no insurance against dental expenses.

How can one evaluate the plan? Several principles are important.

All persons resident in the United States should have available, as a matter of right, comprehensive personal health care services, with equal opportunity of access to the available services throughout the country.

Personal health care services should be provided under arrangements that, to the maximum extent practicable and within a framework of improved provisions for service, make full use of existing personnel and facilities and are acceptable to the people to be served and to those who provide the services.

The availability of personal health services should be assured through a national health insurance system.

The national health insurance program should be an integral part of the national social insurance system. The program should be financed by contributions from employers, employees, self-employed persons—preserving the present provisions which permit employer assumption of all or part of employee contributions—and from federal general revenues.

The benefits of the program should extend to the entire range of services required for the maintenance of personal health, including services for the prevention and early detection of disease, for the care and treatment of illness, and for medical rehabilitation when needed.

Payments for the services provided as benefits of the program should assure full financial protection for the consumers and should be fair to the providers of the services.

The national health insurance program should include provisions designed to contribute toward safeguarding the quantity, quality, effectiveness, continuity and economy of the family health care services it finances.

The administrative arrangements and the finances of the national health insurance program should be designed to encourage the organization of professional, technical and supporting personnel into health teams and groups capable of providing comprehensive health care for families and individuals efficiently and effectively, with compensation through comprehensive per capita payments as an alternative to the prevailing fee-for-service method of payment.

(*Continued on page 35*)

Max W. Fine has been executive director of the Committee for National Health Insurance since its establishment in November, 1968. Earlier that year, he joined the United Auto Workers as senior health consultant. Before 1968, he served as special assistant to the director of the Bureau of Health Services of the Public Health Service, United States Department of Health, Education and Welfare. He organized the first national conference on private health insurance. From 1963 to 1965, he served as chief of research publications for the Social Security Administration.

"The cure for the ills of our medical care system is to allow the 'invisible hand' of Adam Smith a wider role. . . . By greatly expanding the demand for medical care, National Health Insurance would only aggravate the problems of the last ten years and retard innovations by business, labor and insurers."

National Health Insurance: A Social Placebo?

BY KEITH LEFFLER
Assistant Professor of Applied Economics, Graduate School of Management, University of Rochester

IN 1965, the average American family spent $830 on health care; this nearly tripled and reached more than $2,200 per family by 1975.* Of course, these costs are buried in a myriad of taxes, insurance payments, charitable transfers and direct consumer payments. Over the same period, direct, out-of-pocket expenses for health care only rose from $436 to $717. These statistics do not, of course, imply that we receive three times the health care we received in 1965. In fact, over the last ten years the price of medical care has risen twice as fast as the overall cost of living; while we spend 178 percent more on medical care than we spent in 1965, we receive only 50 percent more care.

In response to the upward spiraling cost of basic medical care, Senators Edward Kennedy (D., Mass.) and Russell Long (D., La.) declared 1975 a year of "crisis" in the American health care system, a view shared by the American public. In a recent survey by the Center for Health Administration Studies at the University of Chicago, more than three-fourths of the respondents agreed that "there is a crisis in health care in the United States."[1]

Crises are becoming ever more common in the American economy. Since 1972, our energy and food supplies, our environment, our population levels, and our transportation systems have all been said to be in states of crisis. Apparently, when a commentator believes that the private sector is unable to allocate resources effectively within an economic sector, he cries crisis. The general response to the alleged crisis in the health care sector is a growing clamor for National Health Insurance (NHI). But there is, in fact, no crisis in health care; the rapid price escalation of medical care prices is a transitory phenomena largely brought about by government actions. The solution to the problem is to allow the private marketplace increased freedom in which to discover cost-controlling reimbursement techniques. A change to an NHI system will further weaken incentives to control costs and, in turn, will lead us to a true crisis.

The case for NHI must rest on at least one of the following conclusions about private markets: that they supply an inappropriate level of medical care; that the care provided is inappropriately distributed; that the costs are inappropriately distributed; or that the level of costs is too high. Does the present medical care system provide enough medical care? Is the care fairly distributed? And are the costs fairly distributed?

Armchair theorizing cannot tell us how much of society's resources should be allocated to medical care. Some theorists have attempted to answer this question by referring to our health needs but our health needs are as diverse as our minds are creative and our budgets are large. We daily demonstrate a willingness to trade health needs for other needs; we smoke and drink, work too hard and drive too fast. Some individuals further confuse the issue of the appropriate quantity of health care by proclaiming that health care is a right. Does this mean that health providers cannot discriminate? Does it rather mean that everyone is entitled to a day, a month or a year of free health care? Americans certainly should have the right to decide how much of their energies on average should go into providing health care. This simply means that the appropriate amount of resources devoted to health care can be determined only by reference to the tastes and preferences of mil-

*Research support has been provided by the Center for Research in Government Policy and Business at the University of Rochester.

[1]Reported in the *Journal of the American Hospital Association*, February, 1972.

TABLE 1: Physician Visits per Person before and after Medicare and Medicaid

Income	1963-64	1966-67	1973
Under $3,000	4.3	4.6	6.0
$3,000-$7,000	4.5	4.1	5.2
$7,000-$10,000	4.7	4.3	4.8
$10,000-$15,000	4.8	4.5	4.9
Over $15,000	5.8	4.8	5.1
Age			
Under 65	4.3	4.1	4.8
65+	6.7	6.0	6.5

Source: Charles Phelps, "Public Sector Medicine: History and Analysis," in *New Directions, op. cit.*

lions of individuals in our society.[2] Nonetheless, it is unlikely that we currently underspend, in any sense, on medical care; for we spend more, see the doctor more, take more medicine and go to the hospital more frequently than any other people in the world.

The average American consumes more resources for his health care than the *total* consumption of over half the individuals in the world. Many researchers in the field of public health have recently begun to argue that, based on health effects, we overspend on health care. For example, Nedia Belloc of the California State Public Health Department and Lester Breslow, dean of the University of California at Los Angeles School of Public Health, have found no significant effect from visits to a physician on the health of a sample of 7,000 adults.[3] A large proportion of our health expenditures appears to be spent on doses of placebo ministrations, reassurance and counseling by an interested, professional bystander. It is very difficult to believe that we are consuming too little health care in 1977, yet NHI will tend to increase the amount of health care consumed, with likely little or no effect on the health of the nation.

Although the current level of resources devoted to medical care seems sufficient, these resources might still be inappropriately distributed across the population. In particular, is a family's income a significant deterrent to medical care consumption?[4] Prior to 1965, there was a significant positive correlation between a family's income and its consumption of medical care. In 1966, two major government programs were instituted to aid the poor in the purchase of medical care, Medicare and Medicaid. As a result, the link between income and medical care consumption no longer exists. Table 1 shows the distribution of physician services per capita as related to income in various years. In 1973, poor people consumed on average more health care than the wealthy.

Many writers have complained of the disparity of Medicaid subsidies across the states and most NHI plans call for a standardization of state medical subsidies to the poor. Medicaid eligibility and benefit rules are individually established by the states and the rules vary widely. Yet a diversity across states is desirable; the transfers of wealth should be determined by individual citizens' preferences. If citizens in New York wish to transfer large amounts of their wealth to the poor, they can do so. Yet their decision carries no implications for the appropriate transfers in Alabama or California. To argue for equal transfers of funds to the needy in all states is to argue that some citizens' tastes and preferences should be imposed on others. Such elitism is not part of a democratic, free society. A major benefit of a federal system is the constraint imposed on state and local governments by our ability to move across jurisdictions to one where the government's actions better suit our preferences.

Undoubtedly, there are some deserving individuals with low income opportunities who have no access to subsidized medical care. Families without health insurance or government support could suffer financial ruin from medical expenses arising from an accident or illness. Available estimates suggest that about three percent of the population does not have the opportunity and/or resources to purchase private group health insurance and is ineligible for medical care at public expense.[5] Most individuals in this group are either unemployed or self-employed. To nationalize the entire health insurance industry in an effort to subsidize this small segment of society is a very drastic solution. The government already has bureaucratic interactions with most of these people through social security and unemployment insurance programs. The addition of a special medicare or insurer-of-last-resort program to provide for the unemployed and the self-employed would not be prohibitively expensive and would be a more rational response than a National Health Insurance system.

As pointed out above, medical care price increases

[2]There are many characteristics of health care that make it likely that a complete laissez-faire system would undersupply these services. See Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review,* December, 1963, for an analysis of these problems.

[3]Nedra Belloc and Lester Breslow, "Relationship of Physical Health Status and Health Practices," *Preventive Medicine,* 1972, developed seven statistical rules of good health: 1) don't smoke, 2) get seven hours sleep, 3) eat breakfast, 4) stay within seven percent of your proper weight, 5) exercise regularly, 6) don't drink excessively, 7) don't eat between meals.

[4]The poor by definition consume lower levels of all resources. Given their poverty, it is not advisable for them to consume the level of medical care that the rich do. That is, the resources the government currently provides the poor for medical care could be better utilized to provide better housing, food and education. The poor cannot afford to consume high levels of free medical care if it effectively lowers the transfer to them of more desired goods and services.

[5]See for example Charles Phelps, "Public Sector Medicine: History and Analysis," in C. M. Lindsay, ed., *New Directions in Public Health Care* (San Francisco: Institute for Contemporary Studies, 1976).

TABLE 2: Medical Care per Family; Expenditures, Prices and Quantities: Selected Years 1950-1975

	Hospital Care			Physician Services		
Year	Expenditures	Price Level	Quantity*	Expenditures	Price Level	Quantity*
1950	$101.18	37.7	.96	$ 73.58	62.5	.66
1955	143.05	54.2	.94	91.35	74.1	.69
1960	195.55	73.5	.95	128.39	87.2	.82
1965	280.94	100	1.00	179.55	100	1.00
1967	353.18	124.5	1.01	203.24	111.6	1.01
1969	457.25	164.7	.99	242.21	125.6	1.07
1971	583.93	209.2	.99	302.61	144.8	1.16
1973	712.11	240.3	1.05	354.44	156.2	1.26
1975	903.50	296.5	1.12	428.48	185.1	1.29

*This is a quantity index adjusted to a base year of 1965.

Source: Computed from Barbara Cooper, Nancy Worthington and Paula Piro, "National Health Expenditures, 1929-1973," *Social Security Bulletin,* March, 1974; and Majorie Muller and Robert Gibson, "National Health Expenditures, 1975," *Social Security Bulletin,* February, 1976.

have far exceeded the general rise in prices in the United States since 1965. Relative increases have been most drastic in the hospital sector, as shown in Table 2, which lists total expenditures broken down into quantities and prices for various years since 1950. Especially striking are the sharp increases around 1966 in both hospital and physicians' visit prices. It is not coincidental that 1966 was the year that the Medicaid-Medicare programs were implemented. In a single year, the government increased subsidies to medical-care demanders by nearly $8 million. The most dramatic effect of the increased government role in providing medical care was the rapid escalation of physicians' fees and hospital room charges, the result of a drastic increase in demand in the face of a relatively fixed supply.[6] The increased demand for medical care was of course the goal of the Medicaid and Medicare programs. Nonetheless, the supply of health services can increase only after very long time lags. It takes up to six years to train a physician and just as long to increase a hospital capacity or a medical school capacity. The high prices of 1976 are in part a transitional phenomena signaling and attracting resources into the industry.

The government programs of 1966 are not the only cause of escalating medical care prices. The great reliance on third party payers also helps to explain the absence of effective cost controls. Table 3 shows the distribution of payments among consumers, insurance companies and the government for physicians and hospital services since 1950. In 1975, nearly all (92 percent) of our hospital expenditures were paid for by third parties. When consumers do not directly pay their bills for medical services, the incentive for direct patient monitoring of costs is lost, because any cost savings from the efficient delivery of health care is shared with all purchasers of health insurance. Further, if insurance company A lowers the costs at hospital X, all insurers share the savings. Thus insurance companies will be less vigilant in controlling costs than they would be if they reaped the entire savings. Insurance companies are beginning to develop systems that internalize the gains from cost reductions.

Will the federalization of the payment for medical care control medical care costs? The immediate impact of a NHI plan will be a tremendous increase in the demand for medical care. A plan like the Kennedy-Corman Health Security Act would effectively remove all price barriers to the consumption of medical care. There is an extensive body of economic literature showing that lower prices for health care cause increased demand.[7] This occurs because medical treatment for minor colds, aches and pains or hypochondriac reassurance no longer implies the sacrifice of a dinner for six at McDonald's. However, the absorption of the financing of medical care by the government in no way changes the true resource costs of a hospital bed or a physician's services. It merely hides the costs in taxes and thereby prevents us from making a rational decision as to the best use of our limited wealth.

How might a NHI system control costs when its direct economic impact is to raise prices? It has been estimated that a plan like the Kennedy-Corman proposal would raise the market clearing price of physicians' services fourfold in its first year.[8] Such a boost in prices would not be tolerated by legislators subject to

[6]I have estimated that physician incomes were $7,000 higher than otherwise in 1967 due to Medicare-Medicaid. See Leffler and Lindsay, "The Long Run Effects of National Health Insurance or Medical Care Prices and Quantities," in *New Directions in Public Health Care, ibid.* Many other writers have documented the effects on medical care prices of the government programs. See, for example, M. Feldstein, "Hospital Cost Inflation: A Study of Non-profit Price Dynamics," *American Economic Review,* December, 1970.

[7]See, for example, Joseph Newhouse and Charles Phelps, "Price and Incomes Elasticities for Medical Care" (Santa Monica: Rand Corporation, 1975).

[8]Leffler and Lindsay, *op. cit.*

TABLE 3: Percentage Distribution of Expenditures on Physician Services by Source, Selected Years 1950-1975

	Hospital Care*			Physician Services*		
Year	Direct Payment	Insurance Benefit	Government	Direct Payment	Insurance Benefit	Government
1950	34.2	16.5	45.7	84.8	10.0	4.9
1955	23.6	27.4	45.9	71.2	21.9	6.6
1960	18.6	36.8	42.0	66.0	27.3	6.5
1965	18.5	41.7	37.5	63.2	30.4	6.3
1967	12.3	35.8	49.9	55.6	29.8	14.5
1969	10.4	35.1	53.0	45.7	31.7	22.6
1971	10.2	36.5	51.9	43.8	34.2	21.8
1973	10.0	36.1	52.7	40.5	36.4	23.0
1975	8.0	35.8	55.0	34.5	39.0	26.5

*These do not add to 100 because private charity is excluded.

Source: Muller and Gibson, "National Health Expenditures, 1975," *Social Security Bulletin,* February, 1976.

periodic reelection campaigns. Thus the Kennedy-Corman plan explicitly includes direct controls over prices. At first blush, one way to control prices is to impose large penalties for price increases, which undoubtedly would control the nominal or money price of medical services. Yet such a method of controlling costs has failed time and again. Price controls do not change the fundamental scarcity of medical resources nor affect the value of the resources to consumers. However, price controls change the method whereby we compete for scarce resources. As the experience of gasoline price controls during the Arab oil embargo in 1973 showed clearly, an alternative method of competing for scarce resources when nominal prices are controlled is to see who can wait the longest (and get up the earliest). During price controls, those blessed with patience gain the spoils. Yet the true price is no lower; only the form has changed. In addition, waiting wastes resources, while paying merely transfers them.[9] Price controls also increase discrimination against racial minorities, those who are less attractive, and those with unpleasant personalities. When price is artificially restricted, a physician's appointment book is full and patients are being turned away. The physician may well choose to see those who most appeal to him.

Some writers have recognized the large potential waste involved in rationing by non-price means. They suggest that these costs would be minimized if physicians ration their services according to medical need. Unfortunately this suggestion would be difficult to implement. Most of a physician's time is spent determining the medical needs of his patients. Substitution of less trained personnel in preliminary screening is also costly. The skill of a physician might be most valuable in the early diagnostic stages of treatment. Only the obviously well could be effectively screened by allied personnel. Finally, even if medical needs were easily detectable, physicians should not be expected to allocate their limited time to the greatest needs. Physicians react to the same incentives as construction workers, economists and clergymen. Their overriding goal is not the good of society but their own welfare, and the welfare of their families and their friends. Side payments, social pressures and personal taste will all play major roles in allocating resources if prices are lowered below the market clearing level.[10]

National Health Insurance plans contain more indirect measures designed to control costs. The Health Security Act, for example, requires establishment of Health Security Boards that would review the "reasonableness" of services provided to consumers. Utilization review boards would attempt to prevent providers from prescribing "unnecessary" treatment and would try to eliminate "wasteful duplication" in specialized medical equipment. It is also claimed that the plan would save millions of dollars by taking the profit and high administrative costs out of the handling of bill paying.

However, there are no specifics indicating how government servants will detect unnecessary surgery and unnecessary equipment, or why public employees will be highly motivated to achieve administrative costs savings. In fact, the proponents of the Health Security Act compare current imperfect market institutions to idealized but unattainable government alternatives. The

[9]Elsewhere (Leffler and Lindsay, *op. cit.*), I have estimated the potential waste from rationing by waiting as up to $17 billion per year. This estimate includes only waiting to see physicians, the main bottleneck, because physicians will ration hospital care.

[10]Another cost of price controls is the reduction in supply that is eventually created. The housing shortage in the rent-controlled districts of Manhattan are perhaps the most obvious example. High prices attract resources into production with the promise of high returns. The tremendous demand for admission to medical school is the response to the Medicare-Medicaid price increases. I have estimated that price controls would increase the response time of the health sector by about 10 years if a Kennedy-Corman type plan were adopted.

substitution of bureaucratic agencies for profit-seeking entrepreneurs has not historically promoted efficiencies. The incentives and reward systems within government agencies appear to promote inertia rather than innovation. In the health sector, evidence to date does not prove that cost reductions have resulted from government review boards or government provision of health care. For example, recent studies report that Health Security Agencies in Pennsylvania have had no effect on the level of hospital investment.[11] Another study found that the administrative costs of the processing of medicare claims by government and non-profit organizations were substantially higher and accompanied by more errors than the administrative costs of private, profit-making insurance companies.[12]

WHAT CAN BE DONE ABOUT COSTS?

The villain responsible for the escalating costs of medical care is the "cost-plus" or "reasonable and customary fee" reimbursement system, including government programs for subsidizing health care and private insurers. The role of Medicare-Medicaid in the recent severe health care inflation was crucial because of the enormous reduction in the direct costs of health care. Indeed, today only a minute segment of society has a direct stake in monitoring hospital costs. We should not be surprised when physicians make maximum use of the available resources in a hospital. National Health Insurance will extend these problems because everyone will try to increase the consumption of medical care when the last vestige of direct costs is removed.

A third party payment system is not unique to medical care. For example, most collision repairs on automobiles are paid for by insurance companies. These companies are, however, able to use a system of closed bidding competition among competing shops, thus giving the shop owners a direct stake in their own efficiency. Medical care insurers have a far more difficult task. The link between our bodies and our minds and emotions makes an efficient method of "repairing" the ill hard to evaluate. The personal rapport between physician and patient is important to consumers of medical care. Rapport can even affect medical outcomes. Competitive bidding is thus not a reasonable alternative in the health care sector.

Some writers claim that private insurers have no incentive to control costs because they pass on cost increases in higher rates. This claim ignores a very active form of competition among private insurers. Large corporate employers, for instance, are interested in lower insurance premiums that directly boost their profits. An insurance company that succeeds in lowering the costs of providing health insurance will handsomely reward its stockholders because it will sell a tremendous number of insurance policies. The government could help inquisitive and inventive entrepreneurs to find changes in health care delivery that would control costs. For example, the American health care insurance business is currently dominated by the Blue Cross/Blue Shield plans. These plans have sizable competitive advantages over private commercial insurers. The close link of the Blue plans to the providers of medical care affects their incentives to control costs. Because the Blues are non-profit institutions, no one would directly benefit in a meaningful way from closely monitoring the activities of patients, hospitals and physicians. The Blue plans should be placed on a competitive footing with commercial insurers. Tax differences and price differences by providers should be eliminated.

Even within this constrained environment, private insurers are beginning to demonstrate innovative ways to control health care costs. It is not surprising that markets reacted slowly to a shock the size of Medicare-Medicaid. Three market responses that may control costs seem most important in the immediate future.

Variable Reimbursement Insurance (VRI) is a recent innovative plan to control health care costs.[13] Under this plan, hospitals are placed into expense classes based on their historical costs. Consumers also choose expense class policies. The percentage of a patient's costs reimbursed by the insurance company is then inversely related to a hospital's expense class and positively related to the consumer's policy class. The patient and, indirectly, his physician control, by choice of hospital, a large part of the patient's out-of-pocket costs. With more general adoption of VRI, hospitals would eventually be pressured into providing service of the quality and cost most desired by consumers.

A second recent innovation in private insurance reimbursement offers the rewards from cost controls directly to the primary physician. Individuals and families enrolled in large group health insurance plans are allowed to select a private primary physician from a list of participating doctors. All health expenses are then covered by the policy. The selected physician, in consultation with his patient, makes all the medical care expenditure decisions. The unique feature of this plan is that the physician is essentially paid a fixed amount irrespective of the actual expenses incurred.

(*Continued on page 35*)

[11]Clark Havighurst, "Regulation of Health Institutions," in *Conference on Controls in Health Care* (Washington, D.C.: National Academy of Science, 1974).

[12]See H. E. Frech III, "The Property Rights Theory of the Firm: Results from a Natural Experiment," *Journal of Political Economy,* 1971.

[13]This insurance plan was first proposed by J. Newhouse and V. Taylor, "The Subsidy Problem in Hospital Insurance: A Proposal," *Journal of Business,* October, 1970.

Keith Leffler is the coauthor of *Medical Education: An Economic Analysis of Demanders and Suppliers* (forthcoming) and has written a number of articles on the economics of national health insurance.

"The nationwide volume of malpractice premiums has nearly tripled in the face of these pronounced changes in the malpractice litigation environment."

Medical Malpractice Suits

By Douglas Conrad
Research Assistant, Center for Health Administration Studies, University of Chicago

THE issue of medical malpractice suits in the United States expresses a variety of public concerns, which involve legal and medical problems and social welfare policy in general. The breadth and intensity of these various interests has only recently reached the public agenda, reflecting the fact that the costs of medical malpractice suits borne by health care providers have increased dramatically.

The historical pattern of medical malpractice suits corresponds roughly to (1) an increase in the willingness to sue for personal injury in our society, (2) the growth in skepticism toward social institutions in furthering the public interest, (3) the rapid rise over time, particularly in the period since the enactment of Medicare in 1965, of medical care prices, (4) changes in tort law that have increased the probability of successful suits by plaintiffs, and (5) increases in the inherent riskiness of medical practice placed against a backdrop of rising patient expectations. One cannot disentangle the relative influence of these factors, but each has clearly contributed to the growth in number and size of medical malpractice claims.

Table 1 documents the increase in malpractice premium volume since 1960, which in turn reflects the growth in the size and frequency of claims and the uncertainty facing malpractice insurance underwriters when they rate policies. Because medical malpractice claims are usually filed and settled several years after the malpractice incident, actuarial uncertainty is peculiarly great; insurers understandably adjust their rates to protect against higher expected losses from a given pool of medical injuries. For example, since 1970 the number of claims filed nationwide has increased annually an average of 12 percent, while an average claim payment has doubled in the same period. The increased incidence of awards in the range of $1 million has introduced a further element of "upper tail" uncertainty into the claims distribution, which the actuary must face in setting premium rates. The nationwide volume of malpractice premiums has nearly tripled in the face of these pronounced changes in the malpractice litigation environment. These aggregate trends are noteworthy, but even more striking is the variable impact on different physician specialties documented in table 2.

In addition, there is independent evidence that the rate of injury per 1,000 population from surgical and medical procedures has increased since 1959-1961.[1] So the *potential* pool of claims has expanded even as the willingness to draw from that pool has increased. These phenomena appear to be a continuation of trends begun in the 1930's, coupled with a noticeably rising propensity to sue for damages in the post-World War II period.[2] The triggering mechanisms for the trend should be considered one by one.

First, the increased rate of medical malpractice suits mirrors a movement toward *caveat venditor* (let the seller beware) for injuries of all types. This shift has taken place in product liability suits and suits for nonmedical professional liability (see table 3), although the trend to strict producer liability has been most pronounced in the case of medical malpractice. The seeking of personal injury damages is a result of growing consumer rights advocacy and the increasing specialization and proficiency of plaintiff lawyers in prosecuting liability claims. Since 1960, the courts appear to have moved toward charging losses from personal injury to producers rather than consumers irrespective of whether seller negligence has been demonstrated.[3]

It is a commonplace observation that the American public now exhibits considerable skepticism with regard to social institutions presumably directed to the "pub-

[1]Charles S. Wilder, *Persons Injured and Disability Days by Detailed Type and Class of Accident,* Series 10, no. 105 (Washington, D.C.: National Center for Health Statistics), pp. 1-36.

[2]Secretary's Commission on Medical Malpractice, *Report on Medical Malpractice* (Washington, D.C.: Department of Health, Education, and Welfare [DHEW], 1973), p. 3.

[3]Roland N. McKean, "Products Liability: Trends and Implications," *University of Chicago Law Review,* vol. 38, no. 1 (Fall, 1970), pp. 14-19.

Table 1: Medical Malpractice Premium Volume for Dentists, Physicians, Surgeons, and Hospitals: 1960-1970 (in millions)

Year	Dentists	Physicians	Surgeons	Hospitals	Total
1960	$ 5.1	$ 7.6	$ 19.7	$ 28.7	$ 61.1
1961	5.3	7.9	22.4	30.3	65.9
1962	5.4	8.1	25.2	31.1	69.8
1963	5.6	8.9	30.3	32.2	77.0
1964	5.8	9.6	35.5	33.2	84.1
1965	6.4	10.5	38.5	35.1	90.5
1966	7.0	11.4	43.7	33.2	95.3
1967	7.4	15.2	51.7	35.7	110.0
1968	7.7	19.0	59.7	38.1	124.5
1969	8.9	30.2	110.5	63.0	212.6
1970	11.0	48.7	206.7	104.2	370.6

Source: Mark Kendall and John Haldi, "The Medical Malpractice Insurance Market," in *Appendix, Report on Medical Malpractice,* Secretary's Commission (Washington, D.C.: Department of Health, Education, and Welfare, 1973), p. 509.

lic" interest. In the case of medicine, there is considerable nonpartisan support for the proposition that the health care delivery system requires reform.[4] There is less consensus on the *type* of reform needed. In light of this seemingly shared perception of growing systemic deficiencies, one might anticipate a noticeable decline in personal satisfaction with one's own care and personal physician. Paradoxically, however, public dissatisfaction with the system is not matched in private. In fact, some three-fourths to four-fifths of the population are satisfied with the care they receive and with their doctor(s).[5] This suggests that widespread disillusionment with the medical profession is not a dominant force in the rise of medical malpractice suits.

The rapid post-Medicare climb in hospital and physician charges has undoubtedly played a significant role in the increase in malpractice claims. Even with greater health insurance coverage, the real economic cost of medical care to the consumer has increased and with it the potential loss from treatment-related injury. For example, Angela Holder points out that a substantial number of claims arise when the physician takes extraordinary measures in collecting a fee that the patient fails to pay.[6] In Canada, where universal health insurance prevails but where social conditions are otherwise comparable to the United States, both the rate and the size of medical malpractice claims are considerably lower. One should be cautious in imputing the difference solely to the presence of national health insurance, however, since the propensity to sue for personal injury may be different.

Significant court decisions and statutory reform over the last 10 to 15 years have figured in the rise in claims by increasing the probability that plaintiffs will win such suits. For example, the Darling decision of 1965 identified the legal liability of the hospital for actions of nonemployee physicians.[7] In that decision, the court ruled that the hospital was negligent for failing to require the attending physician, a general practitioner, to consult with orthopedists on the hospital staff. More fundamental to the ease of winning a suit is a legal evolution proceeding along several tracks:

- stricter standards of due care for providers;
- increased acceptance of the discovery rule whereby the statute of limitations for a suit runs from the date of *discovery* of an injury rather than the date of its occurrence;
- the use of the reasonable *man* standard in lieu of customary medical practice for judging informed consent to therapy; and
- more liberal rulings in several jurisdictions permitting testimony of medical experts from outside the local community.

Recent empirical evidence supports the inference that these legal changes are associated with differences in the expected payments for medical malpractice claims.[8]

Finally, the intrinsic riskiness of medical practice has been heightened by the dramatic increase in the pace of technological innovation in medicine since 1945. The health benefits of a sophisticated diagnostic technique like the translumbar aortogram[9] must be weighed against its health risks, which are low in probability but high in severity. Therapeutic procedures performed by specialists in cardiovascular, orthopedic, neurologic, and plastic surgical problems are disproportionately risky, yet these specialties have also taken advantage

[4]Cf. Stephen P. Strickland, *U.S. Health Care: What's Wrong and What's Right* (New York: Potomac Associates, 1972), p. 36.

[5]Theodore R. Marmor, "Rethinking National Health Insurance," *The Public Interest,* no. 46 (Winter, 1977), p. 74.

[6]Angela Roddey Holder, *Medical Malpractice Law* (New York: John Wiley & Sons, 1975), p. 408.

[7]Darling versus Charleston Community Hospital, cited in Holder, *supra* note 6, pp. 214-215.

[8]Melvin W. Reder, "An Economic Analysis of Medical Malpractice," forthcoming in the *Journal of Legal Studies,* tables 1 and 2.

[9]Subcommittee on Executive Reorganization, *Medical Malpractice: The Patient versus the Physician.* Study submitted to the Committee on Government Operations, U.S. Senate (Washington, D.C.: Government Printing Office, 1969), p. 7.

Table 2: Average Premium Increase in Texas 1970-1975 by Specialty (in percents)

Anesthesiology	600%
Cardiovascular disease	500%
Dermatology	350%
General surgery	410%
Family practice	320%

Source: Adapted from Texas Medical Association, *The Medical Malpractice Insurance Crisis in Texas: Its Impact on the Public and Physicians of Texas,* 1976: table A-30.

of substantial technical innovation. As medical *capacity* for health enhancement has increased, the risks of treatment-induced incapacity have also increased. Yet it appears that patient expectations have responded primarily to this growth in capacity, thereby placing less emphasis on the concomitant growth in risk of injury.

Clearly, the gap between expected and actual result is a major force motivating suits. This judgment is supported by the evidence in table 4 that more highly qualified practitioners are precisely the group hit most often and hardest by medical malpractice claims. This table provides only a hint, however, since it does not indicate the number of high risk procedures performed by board-certified vs. non-board-certified specialists.

In one sense, medical malpractice suits are *effects* of the way medicine is practiced. However, forces other than the objective quality of medical care are apparently the primary determinants of the rate and magnitude of suits. Therefore, it is relevant to study how medical malpractice litigation is influencing the pattern of medical practice.

It is often asserted that physicians practice "defensive medicine," in response to the threat of medical malpractice suits. That is, they order more X-rays, more diagnostic laboratory tests, and more consultations and avoid risky yet beneficial procedures. Whether or not defensive medicine generates health benefits worth its costs is the basic question. In fact, the wealth of public commentary and survey evidence on the incidence of defensive medicine is not matched by study of the effect of such practice on health outcomes.[10] The medical malpractice tort liability device is designed presumably to serve two ends: compensation for damages and the deterrence of malpractice by placing liability on negligent parties to the medical care transaction. The practice of defensive medicine is neither a clear-cut social good nor a clear-cut evil. To make that evaluation, we must know whether the health benefits resulting from more conservative medical practice outweigh its opportunity costs.[11] If the benefits more than offset the costs, the current set of malpractice legal arrangements would be judged successful in deterring negligent medical practice, apart from the question of the system's efficiency in compensating those injured.

Besides the Havighurst physician survey there is recent evidence from California of the changes induced in physician behavior by substantial increases in malpractice insurance rates. Insurance company data indicate that physicians are adjusting their mix of services in order to lower their individual premiums.[12] Approximately seven percent of insured physicians in California have made procedural changes of this type. In general, physicians are shifting away from angiography, radiation therapy, shock treatment, and plastic surgery. Family practitioners are tending to reduce surgical caseloads, particularly in obstetrics. Physicians in family practice seem to be changing practice patterns more often, principally by reducing the volume of risky procedures and referring their patients to specialists. Whether this redistribution of medical treatments among practitioners will yield improved health outcomes is an open question.

The Rand study concluded that physician location decisions have not been affected significantly by the malpractice premium increases of 1975.[13] Nor did the research reveal any current general shortfall in available care as a result of the rate hikes.[14] Of course, as the study notes explicitly, the choice of location is determined primarily by long-run expectations of practice environments. In that sense, physician behavior may not be altered today by transitory rate increases; but, if such phenomena persist, physician migration and long-run supply of medical services clearly will respond.

Systematic measurement of the extent to which the increased costs of medical malpractice suits to health care providers are passed on to consumers as increased prices has not yet been undertaken. Still, it is clear that premiums are a legitimate cost of doing business and, to the extent that these costs vary with the volume and type of medical services, they will be reflected in medical fees. The willingness of patients and third-party payers to accept such increases depends primarily on the health-enhancing alternatives available. Since these options are limited severely by the state of the art, the price responsiveness of consumers in the medical care market is relatively small.[15] Conceptually, estimates of the pass-through of costs should include not only

[10]For an example of evidence on defensive medicine see Clark C. Havighurst; "The Malpractice Threat: A Study of Defensive Medicine," *Duke Law Journal,* vol. 5, December, 1971, pp. 939-993.

[11]"Opportunity cost" refers to the value of alternatives foregone by devoting resources to a particular use.

[12]Albert J. Lipson, *Medical Malpractice: The Response of Physicians to Premium Increases in California,* R-2026-PSEC (Santa Monica: Rand Corporation, November, 1976), pp. 42-54.

[13]*Ibid.,* pp. 13-32.

[14]A possible exception is in rural areas, where availability of obstetric care and general care to Medi-Cal patients appears to have been reduced.

[15]Richard N. Rosett and Lien-fu Huang, "The Effect of Health Insurance on the Demand for Medical Care," *Journal of Political Economy,* vol. 81, no. 2 (March/April, 1973), pp. 281-305.

Table 3: Malpractice Insurance Rates for Lawyers, Architects/Engineers, Physicians, Surgeons, and Dentists Shown as Percentages of 1962 Rates for Each Profession

Year	Lawyers	Architects/ Engineers	Physicians	Surgeons	Dentists
1962	100.0%	100.0%	100.0%	100.0%	100.0%
1964	99.0	109.4	115.8	135.5	100.3
1966	106.9	109.4	134.0	157.1	115.9
1968	109.8	181.4	217.6	204.2	121.0
1970	170.7	300.3	540.0	673.9	164.4
1972	*	439.3	667.7	826.7	177.8

Source: Beatrix W. Shear, "Professional Liability Problems among Architects, Engineers, Lawyers, and Accountants," in *Appendix, supra* note 2, p. 643.
*Not available.

price increases due to premium costs, but also increases due to the resource costs of defensive medicine.

INSTITUTED AND PROPOSED REFORMS

Reforms of the prevailing institutional arrangements for medical malpractice litigation may be classified according to their implied (not necessarily expressed) objectives:

(1) reducing the administrative costs of litigating medical malpractice claims;
(2) shifting the liability for medical malpractice from one set of parties to another;
(3) experimenting with alternative insurance mechanisms in order to allocate costs of medical maloccurrences more satisfactorily.

Estimates of the percentage of malpractice premiums ultimately returned to patient plaintiffs range from 15 to 38 percent.[16] Obviously, the administrative costs, in terms of legal expenses, underwriting costs and contingency reserves, are substantial. The economic burden of adversary procedures geared to determining fault has prompted policymakers, physicians, insurance representatives, and analysts to consider alternative means of litigating claims.

Voluntary binding arbitration has been proposed. The way in which arbitration is implemented varies across legal jurisdictions. Some states have statutes specifying the composition of the arbitration panel; some permit future as well as existing malpractice claims to be bound contractually to arbitration; and they vary in their provisions for opting out of the arbitration agreement. Even so, all such contracts share three common properties: voluntary agreement by both parties, provider and patient; the presence of legal and medical representatives on the panel; and a waiver of the right to jury trial subject to opting out provisions.[17] Preliminary evidence from the Southern California Arbitration Project suggests that the resolution of claims by arbitration may be more expeditious and less costly than the available alternative.[18] Such findings await replication in other settings.

Pre-trial screening panels have also been proposed. This concept differs from the arbitration proposal in that panel determinations are nonbinding on the litigating parties. Generally, the panels comprise an equal number of doctors and lawyers, but their focus varies from defense advice to advising both sides of the claim. A study prepared for the HEW Secretary's Commission found that dispute resolution by physician screening panels was about 20 percent of the cost of legal action for a case of mid-range severity, the relative cost of medical-legal panels being about 40 percent to 60 percent.[19]

Another class of reforms is directed at revising tort liability statutes. Statutory change during 1975-1976 has been brisk, and the most active interest has been shown by the medical societies. Indeed, the stake of physicians is challenged most by the recent rise in premiums, and their attempts at redress are defensible, even if one-sided. In general, the legal reforms share one common characteristic: they seek to limit the expected liability of health care providers. This goal may be attained by lowering the probability of a successful malpractice action, and/or by limiting the maximum level of damages (as well as shifting the award distribution downward).

Legislative changes (implicitly) aimed at lowering the probability of success by the plaintiff fall into several classes. Elimination of *res ipsa loquitur,* for example, is controversial. This doctrine, which shifts the burden of proof toward the defendant in situations where there are strong a priori grounds for inferring that the alleged injury resulted from negligence by that defendant, has been eliminated in Alaska, and action is pending in several other state legislatures.

[16]Editors of *Prism,* "Medical Malpractice in Focus: An AMA Source Document," *Prism* (Chicago: American Medical Association, August, 1975), p. 15.

[17]American Arbitration Association, "Statutory Provisions for Binding Arbitration of Medical Malpractice Claims," *Research Report Series* (Washington, D.C.: National Center for Health Services Research, October, 1976), pp. 1-12.

[18]Duane H. Heintz, "An Analysis of the Southern California Arbitration Project, January 1966 through June 1975," *Research Report Series* (Washington, D.C.: National Center for Health Services Research, February, 1977), pp. 1-38.

[19]C. Bruce Baird et al., "Alternatives to Litigation, 1: Technical Analysis," in *Appendix, supra* note 2, pp. 276-277.

Table 4: Paid Claims by Profession, by Specialty

Specialty	Board-Certified Yes	Board-Certified No	Number of Claim Reports	Percent of Total Claim Reports	Average Indemnity per Defendant
Cardiac surgery	11	6	17	1	$ 7,767
Otolaryngology surgery	15	9	24	1	17,268
General surgery, miscellaneous	178	105	283	11	17,181
Thoracic surgery	29	9	38	2	27,061
Urology surgery	45	24	69	3	17,348
Vascular surgery	9	1	10	–	18,375
Anesthesiology	73	77	150	6	22,756
Neurosurgery	44	18	62	3	25,420
Obstetric-gynecology surgery	173	118	291	12	16,803
Orthopedic surgery	143	76	219	9	20,464
Plastic surgery, ear, nose, throat	22	17	39	2	17,935
Plastic surgery, miscellaneous	28	12	40	2	14,299

Source: NAIC, *supra* note 22, p. 13.

Other popular reforms include (1) adoption of a local witness rule which precludes expert testimony by medical practitioners outside the immediate geographic jurisdiction; (2) setting short statutes of limitations (usually two years) that begin running from the date of injury rather than from the date of its discovery; and (3) limitations on contingency fees employed typically by plaintiff lawyers. The impact of the first two reforms is fairly clear, but the effect of constraints on contingency fees is more subtle.

Essentially, the contingent fee arrangement is a mechanism for transferring the risk of zero recovery to the (plaintiff) lawyer in exchange for a correspondingly higher anticipated fee. This device offers the lawyer an incentive to screen claims to determine whether they are meritorious before taking a case. Of course, the flip side of the coin is that if the expected recovery from an otherwise meritorious claim is less than the opportunity value of the lawyer's time in the next best alternative, then the lawyer would be discouraged from accepting the case. This latter hazard is increased when legislative acts limit or eliminate the voluntarily agreed-on contingency fee contract. As contingent fee arrangements are restricted, the threshold for a lawyer to accept a case is also raised, thus lowering the probability that the plaintiff will bring successful suit.[20]

The other class of reforms, those aimed at lowering the size of claim payments, are principally three: (1) elimination of the *ad damnum* clause in the plaintiff's complaint that specifies the amount of monetary damages sought; (2) the initiation of a collateral source rule, which would deduct from judgments any health insurance benefits to the plaintiff and other reimbursements; and (3) the enactment of upper limits on damage awards. The *ad damnum* clause is attacked for allegedly contributing to inflated jury awards. One might counter that an objective statement of the victim's damages provides a prospective benchmark against which the jury (or judge) can peg damage awards. At least potentially, such a practice would reduce the arbitrariness of judicial and jury awards without necessarily increasing their expected magnitude.

On its face, the collateral source rule appears to be a reasonable extension of the idea that the victim ought not to be overcompensated (i.e., total awards from all sources should not exceed the damage suffered). Notice, however, that the deterrent effect on provider negligence is weakened by the reduction in penalty imposed on the provider, who now faces the true damages due to malpractice *minus* insurance payments paid to the plaintiff. Since the plaintiff must presumably pay a premium for insurance benefits, part of the risk for medical malpractice has been shifted back to him.

Clearly, a partial disincentive for patients to insure has been created, since the patient who wins a malpractice suit and is not insured receives damage payments from the court while avoiding the insurance premium. There still remains substantial incentive for patients to insure, however, because of the general desire for risk reduction and because *expected* (by prospective plaintiffs) compensation by the courts may be less than expected malpractice damages. Interestingly, the Ohio Court of Common Pleas recently struck down the state's collateral source rule, finding that the rule violated the equal protection clauses of both the United States and Ohio constitutions because claimants in

(*Continued on page 36*)

[20]It should also be noted that an increased threshold for claim acceptance may lead to a higher win rate *per claim brought* since the average merit of a claim brought has been raised as the threshold has risen.

Douglas A. Conrad was selected for the Advanced Fellowship in Health Services Administration, American Hospital Association/Blue Cross Association, from July, 1973 to June, 1974. He is currently serving as a consultant to the *Project on Implementation Problems of National Health Insurance* funded by the Robert Wood Johnson Foundation.

"The British National Health Service pioneered in providing universal, high quality health care with a comprehensive range of benefits dispensed free at the point of delivery. The . . . system seems to have been relatively successful in containing rising costs of health care delivery and, on balance, in maintaining standards."

The British National Health Service in International Perspective

By Joseph G. Simanis
Economist, Office of Research and Statistics, Social Security Administration

When it was introduced in 1948, the National Health Service of the United Kingdom, which provided health care to the whole population, represented a breakthrough. Only a few other countries had universal coverage.[1] New Zealand began phasing in its universal system in 1939; the Soviet Union also provided health care to its whole population. The United Kingdom, nonetheless, was the first major industrialized Western country to introduce a health system accessible to all its people.[2] The National Health Service was not the country's first government program—a national health insurance system had been launched in 1912—but by 1948 it still covered only 40 percent of the population.

Most West European countries and Japan also had national health programs; but for the most part they were insurance schemes covering only a portion of the population, similar to the one which the United Kingdom had just abandoned. As late as 1955, for instance, the French and Belgian systems covered only 48 and 53 percent of the population, respectively. Subsequently, however, coverage was extended in those countries and is now virtually universal in all of them. Australia and Canada have also moved toward universal coverage.

In West Europe, the Netherlands is an exception to this pattern of nearly universal coverage for medical care, because only 76 percent of the population has access to a full range of health services that are essentially free under the general health care program. The portion of the population excluded, however, is essentially made up of higher income groups who are expected to contract for private health insurance to cover the expenses of their health care. Even this excluded portion of the population has been covered for catastrophic types of illness in a special, universal program inaugurated in 1967.

The United States is also an exception to the prevailing pattern of universal coverage in the developed world. Its national health program now covers only the aged and certain categories of the disabled, roughly about 10 percent of the population.

THE BRITISH EXPERIENCE

A national health service is a form of health care delivery that provides comprehensive medical services that are either free at the point of delivery or involve a minimum of cost sharing by the patient. Funds are generally provided by the government out of general tax revenue. Widespread public ownership of medical facilities is usually, but not always, a feature of the system. Doctors in most cases are employed by the government, but here again there are exceptions.

General practitioners in the United Kingdom, for instance, are self-employed professionals paid on a modified capitation basis. For ambulatory care, New Zealand's national health service depends primarily on private doctors, who receive a flat payment from the government for each consultation and bill the patient for the remainder of their fee. In New Zealand (and in France) copayments required of a patient may be substantial, but the program is designed so that serious

[1] Joseph G. Simanis, *National Health Systems in Eight Countries,* Social Security Administration, Office of Research and Statistics (Washington, D.C.: Government Printing Office). See also Derick H. Fulcher, *A Study of Some Aspects of Medical Care Systems in Industrialized Countries* (Geneva: International Labour Office, 1973); Alan Maynard, *Health Care in the European Community* (Pittsburgh: University of Pittsburgh Press, 1975); and David Alan Ehrlich, *The Health Care Cost Explosion* (Bern, Switzerland, 1975).

[2] Simanis and Peter Benson, "Foreign Health Programs: Changes in Population Covered," *Social Security Bulletin,* January, 1976.

and costly illnesses do not place a heavy burden on the patient.

Early proponents of Britain's National Health Service predicted that costs would decline after the inception of the program, because improved access to health care would result in improved health, lower morbidity, and a subsequent decrease in the demand for health service. Although utilization never dropped, costs rose only modestly in the early years of the program and, as a share of rising GNP (gross national product), costs actually declined from 4.2 percent in 1950 to 3.6 percent in 1954.[3] They remained relatively stable for a few years and then began to rise again, reaching 4.1 percent of GNP in 1960.

Brian Abel-Smith, who studied health cost trends in a number of countries during this period, found that most other countries incurred more rapidly rising costs. He concluded that over a 10-year period it was typical for a given country to add 1 or 2 percent to the share of GNP that it was spending on medical services.[4] In the early 1960's, in collaboration with the World Health Organization (WHO), Abel-Smith conducted what is considered the most definitive comparative study of national health expenditures.[5] He relied heavily on extensive questionnaires sent out to each country to obtain standardized information and data. The results indicated that in 1962 the United Kingdom spent 4.2 percent of GNP on total national health expenditures. All other industrialized countries included in the survey spent a larger portion of GNP on their health care. In the United States, for instance, 5.8 percent of GNP was spent for health care, in Canada, 6 percent, and in Sweden, 5.4 percent.

Several years later, the United States Social Security Administration updated this study, drawing on existing data for Canada, the United States, Sweden, the Netherlands, and France, in addition to the United Kingdom.[6] Estimates were also included for the Federal Republic of Germany, which was not part of the original World Health Organization study. Again, the United Kingdom registered the lowest percentage of GNP devoted to health care—4.8 percent in 1969. Corresponding expenditures in the United States for 1969 were 6.8 percent of GNP and, in Sweden, 6.7 percent. Of the seven countries included in the study, the United Kingdom registered the lowest average annual increase in health expenditures since the findings of Abel-Smith's WHO study. The United Kingdom's annual rate of increase in health expenditures, 9.5 percent, was not low considered alone, but it was in marked contrast to the 15.1 percent annual increase established in the Netherlands.

In 1973, studying approximately the same countries, Robert Maxwell of McKinsey Associates found that the pattern of rankings was roughly the same.[7] Although the share of GNP devoted to health by the United Kingdom had risen to 5.3 percent, in other countries the share had risen to even higher percentages. The United States spent 7.7 percent of its GNP for health care, Sweden, 7.0 percent, and the Netherlands, 7.3 percent.

Incomplete data for subsequent years indicate that the pattern has persisted. However, since 1969 the Republic of Germany has undergone a radical transformation from a relatively low-cost provider of health care to a relatively high-cost provider.

CONTROLS AND RATIONING

Among the specific areas of health care delivery in which the National Health Service seems to have succeeded in keeping costs down is the pharmaceutical field. In this connection, after conducting a study of several countries, R. K. Schicke concluded that Great Britain has relatively low unit costs and utilization levels for pharmaceuticals and, as a consequence, has relatively low overall per capita expenditures.[8] Abel-Smith attributes the relatively low costs to the central negotiation of prices with manufacturing suppliers, conducted against a background of possible legislative sanctions. In the National Health Service, a review system that monitors the prescribing practices of individual doctors also probably plays a role. If a family doctor's prescribing cost exceeds the average for other doctors in his area by 25 percent, he may be asked to explain his procedures. Although few doctors are ever disciplined as a result, the system reminds doctors of the need for economy.

Traditionally, pharmaceuticals have represented a little over eight percent of the National Health Service expenditures. For purposes of comparison, in 1973 in France expenditures on pharmaceuticals represented 23 percent of total personal health expenditures.[9]

The relatively low income of personnel engaged in health services in the British system also provides economies. A recent study shows that of the nine countries in the Common Market, doctors' salaries are lowest in

[3]Economic Models Limited, *The British Health Care System* (Chicago: AMA, 1976).

[4]Brian Abel-Smith, "Value for Money in Health Services," *Social Security Bulletin,* July, 1974.

[5]Abel-Smith, *An International Study of Health Expenditures,* Public Health Paper no. 32 (Geneva: World Health Organization, 1967).

[6]Simanis, "Medical Care Expenditures in Seven Countries," *Social Security Bulletin,* March, 1973.

[7]Robert Maxwell, "International Health Costs and Expenditures—an Hors d'Oeuvre," in Teh-Wei Hu, ed., *International Health Costs and Expenditures,* DHEW Publication no. (NIH) 76-1067, 1976.

[8]R. K. Schicke, "Pharmaceutical Market and Prescription Drugs in the Federal Republic of Germany: Cross-National Comparisons," *International Journal of Health Services,* vol. 3, no. 2 (1973). See also: Mickey C. Smith, *Drugs and Pharmacy Services under the British National Health Service,* SSA Grant No. 56096, July, 1973.

[9]Calculated from data in Georges Rosch and Simone Sandier, "A Comparison of the Health-Care Systems of France and the United States," in Teh-Wei Hu, *op. cit.*

Great Britain. In 1973, general practitioners there earned only about one-third of the income received by their counterparts in the Netherlands and Germany (and in the United States).[10]

British nurses are also paid relatively low salaries, receiving less than the national average wage in manufacturing; ancillary workers in the hospitals are among the poorest paid in the country. It is possible, however, that Britain will follow the pattern established in other industrialized countries and that, in time, hospital workers will upgrade their relatively poor status in earnings and become relatively well paid.

The third area in which the National Health System seems to have established low expenditure levels is in capital investments.[11] For the most part, there has been little building of hospitals in Britain over the past few decades. As a result, physical plant is antiquated. There was some improvement in the 1960's, but in 1973 the government cut back expenditures extensively, in line with other economies.[12] Projections for capital expenditures through the 1970's indicate reduced activity in the field of hospital construction.[13]

The low level of hospital construction has contributed to the shortage of hospital beds in Britain. As a result, a patient may wait a long time for elective surgery. Although waiting lists supposedly do not apply to urgent cases and are only in effect for discretionary surgery, there are apparently exceptions. Thus Michael H. Cooper notes that, for a certain type of brain surgery, children in the Liverpool-Warrington area have encountered a two- or three-year waiting period. During this period, their condition can deteriorate appreciably.[14]

The shortage of funds also affects technological development. As of 1973, for instance, only a fraction of those patients who could benefit from lifesaving renal dialysis were provided with this service. Cooper questions whether optional allocation of resources in this regard has been achieved.

In general, a rather stringent rationing of resources is apparently involved in the more or less successful curbing of costs, particularly with respect to capital expenditures. Some apologists for the National Health Service maintain that, in establishing priorities and in negotiating with doctors, hospital workers and drug manufacturers, a single central authority provides a greater opportunity to counter inflationary demands.

The basic alternative to the national health service approach in health care is national health insurance. The insurance approach is perhaps best exemplified in West Germany, pioneer of all national health programs, which traces its system to 1883. About 90 percent of the population in the Federal Republic is covered, usually all except the higher income groups, who have chosen private coverage instead. The system is funded primarily by joint employer-employee payroll contributions. Most doctors are in private practice and, although most hospital accommodations are in public institutions, the private sector also plays a major role in the country's hospital care. Small copayments are required for drug prescriptions, for some forms of dental work, and for orthopedics. Doctors are generally paid according to a binding fee schedule, based on government guidelines and negotiated for specifics between representatives of the doctors on the one hand and the health insurance organizations on the other.

According to this method, every calendar quarter each Sickness Insurance Fund pays a lump sum to the local doctors' association for the provision of needed health care to insured members and dependents. The overall amount is negotiated between the fund and the association. At the end of the quarter, the association divides the lump sum among the doctors according to the services rendered. If the doctors generate more services than had been estimated, they receive a lower reimbursement per service. It is assumed that this method deters an individual doctor from generating more services than necessary, or more costly services than necessary, since he would then be increasing his income at the expense of his colleagues. The doctors' associations also monitor payments to make sure that the volume of claims and the form of treatment meet established norms.

This form of payment has reportedly been replaced in most cases by a system that corresponds more closely to a standard fee-for-service approach. It is often assumed that the change has driven overall costs of health care upward; but an incisive study of the financial aspects of the problem has not been made.

Although these are the two basic models of government health care programs, in a number of countries elements of both models have been combined; in other countries interesting variations have been devised. Sweden's system, for instance, represents an interesting hybrid combining features of national health insurance and a national health service. The country's national health mechanism, financed by a special form of income

(*Continued on page 37*)

[10]D. Deliege-Rott et al., *Medical Doctors in the Nine Countries of the Common Market* (Belgium, 1976); American Medical Association, *Profile of Medical Practice,* 1975-1976 edition (Chicago: AMA), table 62.

[11]Economic Models Limited; *op. cit.*

[12]*Ibid.*

[13]*Public Expenditures to 1979-80* (London: HMSO, February, 1976).

[14]Michael H. Cooper, *Rationing Health Care* (New York: Halstead Press, 1975).

Joseph G. Simanis specializes in international health comparisons and social welfare in the Communist countries. He served with the State Department as an economist in diplomatic posts and at the office of the President's Special Representative for Trade Negotiations.

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HEALTH CARE AND THE PATIENT'S NEEDS

(*Continued from page 4*)

holds, duplication of tests and uncoordinated care are likely to result. In addition, some bias in the type of treatment the patient is likely to receive is inherent in the specialty of the physician chosen. The relatively large supply of surgeons in the United States, for example, is generally believed to be related to the higher rate of surgery found in this country. Specialists also tend to rely heavily on elaborate and expensive diagnostic tests and procedures, which may not represent optimal care in terms of an overall concept of costs and effectiveness.[22]

Hospital clinics are generally organized along specialty lines; responsibility for a given patient's care is divided among a number of practitioners and changes over time; and most clinics are available only at limited hours. The emergency service is designed to provide neither comprehensive nor continuing care, but is increasingly being utilized by patients from all walks of life when their regular physician or clinic is not available, and may be the only source of medical care for significant numbers of low income households.[23] Because of the extensive and increasing use of hospital ambulatory services, they are seen by some as an important source of much future ambulatory care; a number of hospitals are reorganizing these services so that continuing and comprehensive care can be provided in a manner responsive to patients' needs and preferences.[24]

[22]Kristein, Arnold, and Wynder, *op. cit.,* pp. 457-458; Mechanic, *op. cit.,* pp. 31-32.

[23]Gross, *loc. cit.;* Becker, Drachman, and Kirscht, *loc. cit.*

[24]Jerome H. Grossman, John D. Stoeckle, and James J. Dineen, "New Organizations Out of Old Ones: Teaching Group Practices Out of Private Practice and Outpatient Departments," *Health and Society,* Winter, 1975, pp. 65-73; Arthur A. Beraducci, Thomas L. Delbanco, and Mitchell T. Rabkin, "The Teaching Hospitals and Primary Care: Closing Down the Clinics," *New England Journal of Medicine,* March 20, 1975, pp. 615-618.

[25]For example, Scott K. Simonds, "President's Committee on Health Education," *Hospitals,* March 1, 1973, pp. 54-60.

[26]Katherine G. Bauer, "Averting the Self-Inflicted Nemeses (Sins) from Dangerous Driving, Smoking, and Drinking," in *Consumer Incentives for Health Care,* pp. 6-10.

[27]Howard Waitzkin and John D. Stoeckle, "The Communication of Information About Illness," *Advances in Psychosomatic Medicine,* 1972, pp. 184-186 ff.; Barbara M. Korsch and Vida Francis Negrete, "Doctor-Patient Communication," *Scientific American,* August, 1972, pp. 66-74; Lowell S. Levin, "The Layperson as the Primary Health Care Practitioner," *Public Health Reports,* May-June, 1976, pp. 207-208.

[28]Walter J. McNerney, "The Missing Link in Health Services," *Journal of Medical Education,* January, 1975, p. 18.

Although for many years health education has been regarded as a function of personal medical care as well as a component of community health services, it has received relatively minor attention and financial support. As the cost of treating disease and pressures on the available sources of medical care mount, however, public attention is increasingly being directed to the importance of education for disease prevention, the appropriate use of services, and self-care by laymen.[25]

Behavioral contributions to such major health problems as lung cancer, coronary heart disease, alcoholism, drug addictions, and automobile accidents suggest that health education has a significant potential for reducing both the medical care costs and the human suffering that result from these conditions. Thoughtful physicians believe that the identification of risk factors and preventive health education are essential aspects of good medical care, although they are frequently neglected. There is also considerable interest in developing more effective community health education and behavioral modification programs directed to disease prevention. Because much basic information on the behavioral causes of major health problems is already widely known and because the behavior involved is imbedded in the American culture and economy, education alone may have only limited effects. Regulation and taxation of harmful products, like automobiles and cigarettes, and changes in attitudes toward individual responsibility for avoiding preventable diseases are probably necessary before any significant changes occur.[26]

Health care providers should also be an important source of education to patients under their care, but available evidence indicates that communication between doctors and patients is frequently very limited. Good patient care requires a discussion of the patient's concerns and the provision of information on the nature of his condition, the reasons for the proposed treatment, and its likely effects. When this is done, patients can make more informed choices and are more likely to comply with the treatment.[27] Health care providers can also assist patients in making more appropriate use of their services through education on the significance of symptoms, problems they can care for themselves, and when the services of experts are required. Patients with chronic conditions need medical supervision, but can participate actively in their own care when adequate information and counseling are provided.[28]

Another important problem for the consumer is finding an appropriate source of care. Except for a few directories providing only limited information, when medical care is needed almost no assistance is available to the consumer in selecting a physician or hospital. Most physicians are reluctant to encourage consumer education and counseling for this purpose. But given the diversity in the quality and types of medical care available and the differences in consumer preferences,

resources must be developed to make possible more informed choices with respect to the point of entry into the medical care system.

OTHER PREVENTIVE SERVICES

The control of environmental pollution, immunizations, and programs for the early detection of disease are also important components of a comprehensive program for disease prevention. Although programs for the control of environmental pollution are administratively outside the medical care system, they play an important role in preventing a number of major health problems and they may be one of the most important factors in the control of many cancers. Immunizations and vaccinations have largely eradicated formerly common diseases like diphtheria, measles and poliomyelitis, but unfortunately these diseases are beginning to appear again in increasing numbers as more children are not protected against them in early childhood.

The value of screening populations for the early detection of disease is less generally agreed upon. The cost per case of disease discovered is frequently high, and in many cases early detection has not led to effective intervention. Screening programs directed to high risk populations, however, and related to assured access to medical care when indicated can lead to earlier and more effective treatment for such serious health problems as cervical cancer, hypertension (and the coronary heart disease and strokes that are related to it) and glaucoma. Comprehensive periodic health examinations can also have a significant impact on the health of populations if appropriately directed to high risk groups and related to treatment. Physicians in private practice can also play an important role in the early detection of disease among the patients and families of patients under their care.

With the increased financial support available for health services to the poor through Medicare and Medicaid, the utilization rates for physicians' services among low income populations have risen above those of higher income levels. The poor continue to show significantly higher rates of illness and disability, however, and utilization indexes based on the need for medical care show lower use of services by the poor than other groups.[29] Other signs of inequity are the still higher disability rates among poor non-whites and their lower utilization of physicians' services.[30] Although many of the causes of these less favorable indexes of health status lie outside the functions of the medical care system, barriers to the effective use of services are part of the problem.

Deficiencies in the Medicare and Medicaid programs and the inadequate availability of medical care in low income areas have been mentioned. Studies of Medicaid programs have indicated considerable abuse of the system both by providers and users and (especially among physicians and clinics catering to this clientele) the provision of poor quality care.[31] Cultural differences between providers and low income clients and the bureaucratic organization of services at most hospital outpatient departments also act as barriers to the appropriate use of services and to good doctor-patient relationships. Reorganization of hospital ambulatory services may help to alleviate the problem, but neighborhood health centers oriented to ethnic and racial neighborhood populations will apparently continue to be needed in many low income areas, despite the problems that have been associated with them.[32]

SERVICES FOR THE ELDERLY AND CHRONICALLY ILL

More people are living longer to an age when their needs for medical care and for assistance with personal care and the activities of daily living rapidly increase.[33] In addition, many younger people also require long-term care. These include the mentally ill and retarded and those with other chronic illnesses and physical disabilities. For individuals who cannot care for themselves, the major alternatives available today are care by members of their own families or institutional care. Relatively little assistance is available to families who undertake this care, and, increasingly, either there is no close relative or the family is unable or unwilling to care for the elderly and disabled. Nursing homes and other institutions for the long-term care of the elderly have increased rapidly since 1966, and now account for more than 60 percent of all inpatient beds in the United States.[34]

Although there is great variability in the quality of care provided in institutions for long-term care, many are little more than custodial warehouses, providing neither necessary services nor humane attention. Most institutions for the chronically ill and retarded are

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[29]Aday, *op. cit.*, pp. 216-219 ff.

[30]Davis, *op. cit.*, pp. 314-315.

[31]HEW, *op. cit.*, pp. 128-129; Avedis Donabedian, "Effects of Medicare and Medicaid on Access to and Quality of Health Care," *Public Health Reports,* July-August, 1976, pp. 327-329.

[32]Herman, *op. cit.*, pp. 19-21; Emil Berkanovic and Leo G. Reeder, "Can Money Buy the Appropriate Use of Services? Some Notes on the Meaning of Utilization Data," *Journal of Health and Social Behavior,* June, 1974, pp. 94-95.

[33]According to recent estimates based on the National Health Survey, 39 percent of all non-institutionalized persons 65 and older have some limitation in their ability to carry on their major activity (employment or household activities). Public Health Service, *Current Estimates from the Health Interview Survey, 1974,* Vital and Health Statistics, Series 10-no. 100, p. 15. In 1970, 5 percent of those 65 and over were in long-term institutions. Mary Grace Kovar, "Health of the Elderly and Use of Health Services," *Public Health Reports,* January-February, 1977, p. 16.

[34]George A. Silver, *A Spy in the House of Medicine* (Germantown, Md.: Aspen Systems Corp., 1976), pp. 74 and 154-55.

publicly owned and suffer from a severe shortage of funds. As a result, their professional staffs are limited in number, and much direct patient care is undertaken by poorly paid aides, many of whom are not well suited to this type of work.[35] Although the number of patients in psychiatric hospitals has been sharply reduced as the result of new medicines and community mental health programs, conditions in these institutions have not greatly improved. Most elderly people in institutions live in nursing homes, 80 percent of which are privately owned. The quality of care found in them, while highly variable, is also poor in all too many cases.[36]

The care of the chronically ill and elderly could be improved by the application of stricter standards of quality control, which should be feasible since many operate under public auspices or depend heavily on public funds, Medicare, Medicaid and Social Security. Another more important policy decision would be to encourage the development of more adequate programs designed to permit individuals needing care to continue to live in private homes, alone, with their own families, or with others in the community. Home health services, personal services and financial support to households providing this care would be required, but would probably be a less expensive and more humane way to meet the needs of those requiring long-term care.

In the wake of rapid expansion in medical knowledge and technology, the American health care system has developed major imbalances between specialty and primary care, in its distribution of facilities and physicians, and in its emphasis on the technical side of disease treatment rather than on the sustaining aspects of medical care or the prevention of disease. Health insurance and public support for the care of the most needy segments of the population have reduced some inequities but have ignored other inequities and have contributed to the inflationary spiral of medical care costs. Although programs have been developed that demonstrate some of the ways in which medical care delivery could be made more efficient and effective, no overall policies that would overcome the nation's major health care problems have yet been determined. It is clear, however, that only a broad view of the causes, control, and treatment of disease and disability will lead to a substantial impact without an unreasonable allocation of resources to the health sector of the economy. ■

[35]Robert N. Vidaver, "Underfinanced Services in the Public Sector: The Interrelationship of Funding, Service Patterns, Manpower, and Allied Health Professions Education," *Medical Care,* March-April, 1971, pp. 169-172; Julius A. Roth, "The Public Hospital: Refuge for Damaged Humans," in *Where Medicine Fails,* Anselm L. Strauss, ed. (New Brunswick, N.J.: Transaction Books, 1972), pp. 56-61.

[36]Silver, *op. cit.,* pp. 152-157; Mary A. Mendelson, *Tender Loving Greed* (New York: Alfred A. Knopf, 1974).

THE RIGHT TO HEALTH CARE

(*Continued from page 8*)

health care, rising costs and life-and-death decisions are inevitable.

Thus, ironically, it may be an advantage that the United States is the only advanced country that has not had a national health service or a national health insurance system since the end of World War II. By and large, all countries that have such a service or system are committed institutionally and ideologically to the scientific model of medicine as the means of health care. The results in terms of costs are already evident in England and Sweden; the decision problems are evident in all cases.

The United States is likewise committed to the medical model, but the final decisions regarding how health care will be made a right and financed have not been made. There is still time, in other words, to examine the effects of an uncritical acceptance of the medical model, to consider the legitimate place and role of scientific medicine, and to evaluate alternative models. It is perhaps still possible to establish a flexible system that would permit people to realize their right to health care in ways that correspond to their own needs, beliefs, and conditions, rather than those of the medical professions, the hospitals, and the pharmaceutical and medical equipment industries. ■

VOLUNTARY HEALTH INSURANCE

(*Continued from page 12*)

> We need to inform ourselves about the ways in which our own habits and lifestyles may be seriously damaging to health and learn more about the ways of changing the way we live when hazards are recognized. We must learn to identify serious man-made environmental health hazards and find ways to diminish them. We are determined to do everything in our power to improve the health of the public.

Efforts of the kind envisioned by President Carter and Secretary Califano have been multiplying in recent months. Blue Cross Plans have initiated programs of health education and preventive services for their subscriber groups and their communities. Schools are strengthening and expanding their health education classes for young people. Industry is organizing fitness programs for employees; many nationwide corporations have started offering smoking-cessation clinics, dietary instruction, and special assistance for employees with alcohol, emotional and family problems.

Significantly, within the medical profession itself, there is an awakening interest in preventive medicine, health education, and what has come to be known as the holistic approach—comprehending health in the context of the overall life experience, not just as the absence of disease. New programs in holistic medicine

and humanistic medicine have been initiated in medical schools, hospitals and communities; professional journals and meetings of professional societies increasingly recognize that concern for healthy behavior and the prevention of illness are the responsibilities of the practicing physician as well as the public health department.

It seems certain that all these efforts will be continued and intensified, and that scientific medicine will continue to find new and better ways to diagnose and treat disease. For the most part, the role of health insurance will continue to be the protection of those who are sick and injured; but clearly the future roles of the health professions and the health insurance industry will include active concern for keeping people well. ■

THE CASE FOR NATIONAL HEALTH INSURANCE

(*Continued from page 16*)

There should be public control of the basic policies governing the program, and full public accountability for its financial and operational activities.

There should be appropriate provisions for effective participation by consumers and providers both in the development of the national health insurance program and on the advisory councils assisting in its continuing public administration.

The national health insurance program should be so structured and have such inter-agency relationships as to enable it to influence substantially the accelerated development of needed health manpower and facilities and their availability, and to this end shall contribute substantial and assured continuing financial support toward the national development of adequate manpower, facilities and organization needed for the effective delivery of comprehensive personal health care services in all parts of the country.

Although primarily directed to the development and support of comprehensive personal health care services, the national health insurance program should also have concern for the development of effective community health and welfare programs at the national, state, regional and local levels through comprehensive community health planning.

The national health insurance program should provide for studies and demonstrations which give promise for continuing adjustment of the health services so as to serve the changing needs of people in the most efficient and effective manner consistent with sound professional goals and standards and so as to utilize expanding medical knowledge and skill.

The national health insurance program should be designed and developed in accordance with these principles and policies so that it would function not merely to increase national expenditures for health services but also to contribute to the control and elimination of present wastes and extravagances and toward maximum practical effectiveness and efficiency in the delivery of and payment for comprehensive health services of good quality commensurate with our need and potential.

Some critics of a national health insurance plan based on these principles contend it does not go far enough. They say a program like Health Security would fail to deal with problems of environment quality, poor living conditions, dilapidated housing, and other conditions responsible for much ill health in America. It is true that Health Security is not a panacea. It will not cleanse the environment or improve living conditions and housing. All it will do is make real the principle that the poor, the deprived and the working people of the United States have the same right to health care, and to life itself, as the affluent. ■

NATIONAL HEALTH INSURANCE: A SOCIAL PLACEBO?

(*Continued from page 21*)

The physician becomes financially responsible for the patient's hospital expenses, drug and medical expenses and physician expenses. The physician thus feels the sting of high costs[14] and has the incentive to monitor hospital charges and the cost of diagnostic tests. The patient still bears the responsibility for monitoring the adequacy of the overall level of care provided. The insurer makes available alternative participating physicians and alternative, traditional health insurance plans so that displeased patients may penalize physicians who skimp on care by withdrawing their patronage.

The third competitve mechanism that can lead to efficiency in the supply of both hospital services and physician services is the Health Maintenance Organization (HMO). For more than 50 years, HMO's have provided a prepaid centralized system of complete medical care. The incentive to control costs again comes from the inverse relationship between costs and returns or profits. However, HMO's are necessarily of large size, because they operate their own hospitals. The distance from the physician for many enrolled patients seems to limit the attractiveness of the HMO for most of the American public. Nonetheless, if they are given the freedom to compete on an equal basis, HMO's offer a cost-efficient alternative to the traditional decentralized health delivery system. Competing hospitals must then become more efficient or face drastic reductions in their patient loads when the costs of HMO plans fall below the costs of reimbursement insurance plans.

HMO's have, however, been hindered throughout

[14]In fact, the physician shares any cost overruns with the insurance company at a declining rate. The physician's liability is also limited in order to mitigate the risk borne by the doctor because of his few patients.

their history by restrictive state and federal legislation. For example, the HMO act was hailed in 1973 as a potential savior of the medical care system. As originally drafted, the measure overrode state laws impeding HMO's. Yet the sponsors of the Health Security Act added an extensive list of required services and enrollment guidelines before HMO's could qualify for federal subsidies. Competing hospitals received federal subsidies with far fewer restrictions on the services that must be provided. The effect was to increase the costs of HMO's and to limit their potential as attractive alternatives to the traditional insurance plans.

These plans are only a small sample of the methods by which entrepreneurs are attempting to control medical care costs. In 1976, the Council on Wage and Price Stability published a sample of 126 projects initiated by large corporations, unions and private insurers to control the costs of health insurance. William Lilly III, who directed the study of health costs, predicts "a mind boggling range of innovations in the near future."[15] Clearly, the government can play a valuable, active role in encouraging cost-reducing innovations by removing many obstacles to free market solutions.

State licensing laws, for example, currently discourage any experimentation in health care delivery techniques. Physicians, the most highly trained individuals in our society, spend a great deal of their time performing tasks that require a much lower and cheaper level of training. Yet a physician faces loss of his license to practice medicine if he delegates these tasks to assistants or nurses. One response to this problem would be institutional licensure. Hospitals, HMO's and physician groups would be licensed as institutions. The treatment techniques and technologies would be controlled internally by the institutional groups. Both insurance companies and individual patients would monitor the institutions via existing legal channels. Licensure boards would have access to case histories, providing as much control as current licensure review boards. Entirely new health care occupations would be developed in response to the increased freedom in health care delivery choices. Cost could be substantially lowered.

The federal government could also remove the bias against for-profit hospitals in federal subsidy programs like Hill-Burton. Non-profit institutions have fewer incentives to control costs since no "owners" directly gain a profit equal to savings in costs. The competition from private hospitals could help to force the adoption of cost efficient techniques by providing a strong available incentive, the threat of annihilation.

Many other government agencies and laws shackle the free enterprise system in controlling costs. One particularly costly intervention has been the codification by state legislatures of the competitive restrictions we call "ethical codes." Physicians, for example, cannot work as salaried employees for profit-making institutions in most states. This limits HMO's to non-profit status with the accompanying attenuation of cost-controlling incentives. Physicians are also prohibited from advertising by all state licensing laws. This makes the gain from controlling costs smaller since an innovative physician cannot inform potential patients of his superior conduct.

The cure for the ills of our medical care system is to allow the "invisible hand" of Adam Smith a wider role. Nearly all Americans are already free from worry about unexpected medical bills. Those individuals without access to medical insurance can be aided by specific, narrowly focused programs. National health insurance cannot control medical costs because it fails in the most fundamental way to provide true incentives to control costs. Recent actions by the Federal Trade Commission against medical society "ethical" rules and controls over Blue Shield plans offer hope for the future efficiency of the health care system. By greatly expanding the demand for medical care, National Health Insurance would only aggravate the problems of the last ten years and retard innovations by business, labor and insurers. ■

[15]As quoted by A. Ehrbar, "A Radical Prescription for Medical Care," *Fortune*, February, 1977.

MEDICAL MALPRACTICE SUITS

(*Continued from page 26*)

malpractice suits would thereby be treated differently than claimants in other personal injury suits.[21]

Finally, and perhaps the most controversial of the tort liability reforms, is the statutory limit on provider liability for medical malpractice damages. These legislated caps range from $100,000 to $500,000, and the lower court in Idaho and the Supreme Court in Illinois have already ruled such limits unconstitutional. State medical society officials in Indiana, California, Florida, Louisiana, Oregon, and Wisconsin are also awaiting court determinations on the constitutionality of their respective caps.[22] Court decisions to be handed down in the next few years will inform us as to the success of such direct strategies aimed at a *symptom* of the problem.

Provider responses to the insurance problem have taken a variety of forms:

(1) In some 22 states, legislation creates joint underwriting associations, which offer malpractice insurance to physicians as a last resort where no other insurance exists. Such plans have been criticized, particularly in states where they exercise a monopoly, for exorbitant rates and overly restrictive limits on coverage.

(2) In at least 10 states, the medical society has either

[21]*Graley versus Satayatham*, 343 N.E. 2nd 832, 1976.

[22]National Association of Insurance Commissioners, *NAIC Malpractice Claims* (Milwaukee: September, 1976), p. 95.

established or received authority to establish self-insurance plans. Although the sample size for comparison is small, the preliminary evidence suggests that where such plans face competition from other insurers, they respond with comparable prices and higher coverage limits per claim. Of course, only time will tell whether or not the self-insurance mode can succeed.

(3) Besides the state insurance funds in seven states, in two areas of the country with populations too small to support individual state plans—the Far West and the Upper Plains—groups of states are exploring the creation of regional self-insurance plans.

In addition to the local and state private/public mechanisms, three major pieces of federal legislation have been submitted to Congress:[23]

(1) S-215 (Inonye-Kennedy) would create no-fault insurance, a federal medical injury compensation fund, legal fees based on time spent, compulsory review of physicians by PSRO's,[24] payments to physicians restricted to assigned fee schedule, and national licensure/relicensure of physicians;

(2) S-482 (Kennedy-Inonye) would establish state-run, nonbinding arbitration panels in accord with federal regulations and would include regulation of legal fees and doctors similar to S-215; and

(3) S-188 (Nelson) would enact a federal insurance fund to pay any insurance or reinsurance carrier's losses above $25,000. Physicians would not be charged for this catastrophic protection, which would be limited to states with nonbinding arbitration panels.

Generally speaking, these federal proposals socialize the costs of medical malpractice suits in exchange for administrative mechanisms to reduce legal costs and/or the acceptance by physicians and lawyers of regulation on their professional behavior. The logic underlying such bills is that the deterrence foregone by shifting costs away from health care providers and spreading them over the general population will be outweighed by the gains in lower administrative costs and tighter regulation of physician and lawyer fees. The validity of such implicit assumptions is beyond the scope of this paper. But it is important to discuss briefly the most revolutionary innovation being considered: "no-fault" medical malpractice insurance.

The hypothetical advantage of no-fault insurance is its elimination of the need for prolonged determination of fault, versus the hypothetical disadvantage of eliminating the incentive to avoid accidents. In the malpractice setting, several commentators have noted the possibility that the administrative costs of determining the proximate cause of an injury with no-fault may bulk large enough to offset its potential savings. Their analysis rests on two propositions: (1) without the need to prove "fault" there will be a new supply of claims, for which a finding of whether medical care "caused" the alleged injury will be relatively more difficult; (2) the determination of whether the provider "caused" the injury and whether that provider was "at fault" are so closely linked in logic that their administrative costs are similar for any given case.

We have not examined the experience of other countries with no-fault because the only international study available, referring to New Zealand,[25] was published before that system had been in operation long enough to permit one to draw inferences. Without looking at the empirical evidence, we can consider briefly a proposal called *medical adversity insurance*.[26]

The essence of this approach is to identify a set of compensable events. These events (the example illustrates a list of such events for orthopedic surgery) are chosen to satisfy certain conditions: they must represent *adverse* outcomes of medical care *and* such events must be judged as avoidable by the provider with a "high" probability. To achieve optimal deterrence of avoidable accidents, one would place the costs of avoidable maloccurrences directly on the provider of care. In contrast, the costs of relatively unavoidable adverse outcomes would be spread more generally. Of course, there is no neat line of demarcation between avoidable and unavoidable, but the insight of this approach is basically a recognition that incentives for good medical care need to be clear and prospectively defined if they are to induce the desired behavior. It is entirely possible that the lack of such clarity and prospective definition is a major source of the fundamental difficulties in our current system. ■

[23]Claude E. Welch, "Medical Malpractice," *New England Journal of Medicine*, June 26, 1975, p. 1376.

[24]PSRO's are Professional Standards Review Organizations, physician self-review mechanisms established for Medicare, Medicaid, and Maternal and Child Health Care patients.

[25]Arthur H. Bernstein, "No-Fault Compensation for Personal Injury in New Zealand," in *Appendix: Report of the Secretary's Commission on Medical Malpractice* (Washington, D.C.: DHEW, 1973), pp. 836-848.

[26]C. Havighurst and L. Tancredi, "Medical Adversity Insurance: A No-Fault Approach to Medical Malpractice and Quality Assurance," *Health and Society: Milbank Memorial Fund Quarterly*, Spring, 1973, p. 125.

THE BRITISH NATIONAL HEALTH SERVICE

(*Continued from page 29*)

tax, plays a relatively minor role in the administration of health care delivery and pays for only a small part of the cost. Most medical facilities, both for primary care and hospital treatment, are operated by local community governments and are financed chiefly from their budgets.

The health care program in Australia presents another distinctive model. Until recently, it provided health care financed through private health insurance companies that were heavily subsidized by government funds. In mid-1975, the government replaced this

system with a national health service called Medibank, because previous efforts to bring the poorest segments of the population into the system had proved ineffective. More recently, a change has been made, permitting anyone to opt out of the public program in favor of adequate private coverage.

Canada provides another variant in the pattern of health care delivery. In the past, a number of provinces instituted systems which, in essentials, resembled other national health insurance programs. Today, although a few provinces still provide for the payment of premiums, the prevailing federal-provincial arrangement, which has superseded and transformed earlier programs, corresponds more closely to a national health service pattern. Nonetheless, since the range of benefits is less comprehensive than in many other countries (usually leaving out pharmaceuticals and dental care, for example), the private insurance industry has found ample opportunity to provide supplemental, optional coverage.

In most advanced countries today, the literature related to health care often speaks of a crisis in rising costs, reflecting a universal concern with this problem. The United Kingdom is no exception. Nonetheless, the British system has encountered relatively less of an increase than other countries.

Ironically, private health insurance has indirectly been regarded as a cost-containment feature in a number of national health programs, because with private health insurance coverage a patient may seek special, more expensive private treatment. Since doctors could then supplement their basic incomes from a standard national program by charging higher fees to patients accepted on a private basis, they would theoretically be willing to accept lower remuneration from the public program. West Germany and Great Britain have both left room for supplemental private practice, by very different approaches. Private practice has come under increasingly heavy attack in the United Kingdom both by the public and by government, apparently from a growing conviction that its existence promotes a two-tier system, one free and inferior, and the other expensive, but with high standards.

In a discussion of the British National Health Service the value of financial savings if the system is providing inferior health care is challenged, particularly in view of the numerous shortcomings of the system that are prominently reported.

On balance, researchers who have treated the subject in depth maintain that British health care measures up adequately in comparison with other countries, where the reality also departs from the ideal. For instance, although it is recognized that the United Kingdom's capitation approach encourages primary doctors to refer their patients, sometimes unnecessarily, to specialists, critics of the fee-for-service approach argue that such a system encourages unnecessary treatments, including dangerous and costly surgery.

In response to the suggestion sometimes encountered that the United Kingdom does not spend enough on health care to maintain high standards, writers like Abel-Smith cite the available data on crude health indicators.[15] In fact, Abel-Smith concludes that the level of health expenditures in advanced countries has little relation to the health status of the population, at least as measured by crude health indicators. Cooper notes that much of the progress in health care must be credited to environmental and economic factors rather than to providers of health services.[16] Dr. Kerr White suggests that only about 20 percent of medical procedures in any country are truly useful; the others, at best, serve a placebo function.[17]

The British National Health Service pioneered in providing universal, high quality health care with a comprehensive range of benefits dispensed free at the point of delivery. While most other industrialized countries now also have universal coverage under their health care systems, only a few provide a full range of services free or at nominal charge.

The British system seems to have been relatively successful in containing rising costs of health care delivery and, on balance, in maintaining standards. Much of this success, however, seems to be due to the stringent rationing of resources by a central government authority, to the detriment of some suppliers and some patients. Rationing in some form is a necessary part of all health systems. Yet there are so many variations in health care programs and approaches that it is reasonable to presume the possibility of better solutions. The situation warrants more research in order to determine and evaluate a wide range of alternative approaches to the provision of health care. ■

[15]Abel-Smith, *Value for Money in Health Services* (London, 1976).

[16]Cooper, *op. cit.*

[17]Kerr White, "Medical Care Elsewhere," in Irving Goodwin, ed., *Paying for America's Health Care* (Boston, Mass.: Publishing Science, 1973).

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VIRGINIA C. KNIGHT ■

TWO MONTHS IN REVIEW

A Current History chronology covering the most important events of May and June, 1977, to provide a day-by-day summary of world affairs.

INTERNATIONAL

Arab League

June 20—Arab League officials end a 12-day meeting in Alexandria, Egypt; they place 12 corporations on the League boycott list; 5 American companies appear on the list for the first time.

Belgrade Conference

June 15—In Belgrade, Yugoslavia, 35 nations begin to discuss procedural rules for a fall conference to assess the 2-year-old Helsinki Declaration on European Security and Cooperation; the U.S. and Canada and all European countries except Albania are represented by the 200 diplomats present.

Club of the Friends of the Sahel

June 2—Representatives of 20 countries and international development groups conclude their meetings in Ottawa, Canada; they announce a $3-billion, 5-year program to aid the economies of African countries in the Sahel; the group is known as the Club of the Friends of the Sahel.

Commonwealth Conference

(See also *Rhodesia*)

June 8—In London, the heads of governments of the Commonwealth open their conference; President Idi Amin of Uganda has been deliberately excluded. The leaders of 33 Commonwealth countries will end their discussions June 15.

Conference of Western Industrial Democracies

May 7—U.S. President Jimmy Carter and 6 leaders of the other Western industrial democracies confer in London.

May 8—After 2 days of negotiations, the leaders of the industrial democracies conclude their summit conference; they agree to look for common economic solutions.

Conference on International Economic Cooperation

May 29—The 18-month Conference on International Economic Cooperation, with representatives from 16 industrial nations and 19 developing countries, ends its sessions, which were aimed at improving relations between rich and poor countries.

Council for Mutual Economic Assistance (COMECON)

June 22—In Warsaw, the Prime Ministers of the COMECON countries end their 2-day meeting; they agree that they must jointly develop self-help methods to solve their energy and raw material problems.

European Economic Community (EEC)

May 22—Meeting in Maidstone, England, the ministers of the 9 Common Market countries agree to revise their rules before accepting any new members, after 2 days of talks.

European Free Trade Association (EFTA)

May 13—Leaders of the 7 European Free Trade Association countries meet in Vienna; they stress the need for closer cooperation with the Common Market countries after the removal of customs barriers between the members of the European Free Trade Association and the 9 Common Market countries on July 1.

Geneva Convention on the Rules of War

June 10—After 4 years of meetings in Geneva, representatives of 109 nations agree to revise the 1949 Geneva conventions in light of modern warfare; the protocols agreed on will not be open for signature by the countries until December.

International Terrorism

May 23—6 South Moluccan terrorists living in the Netherlands seize 105 schoolchildren and 6 teachers in a school in Bovensmilde, Netherlands; 7 other terrorists seize a train and hold 50 passengers as hostages near the village of Onnen; the action is intended to force the Dutch government to aid in the recovery of the Moluccan homeland in the East Indies from Indonesia.

May 28—The Moluccans free the schoolchildren, many of whom are ill; 17 children are hospitalized.

June 11—Dutch Marines rescue 49 hostages from the train and 4 from the school where they were held hostage by South Moluccan terrorists; 2 train passengers and 6 Moluccans died in the rescue assaults.

Middle East

May 1—Farouk Kaddoumi, head of the political division of the Palestine Liberation Movement (PLO), issues a set of demands for the upcoming Geneva conference on the Middle East. He says the PLO must receive a separate invitation to participate in the conference as an active delegation; in addition, he declares that the issue of Palestinian refugees must be discussed as a separate issue.

North Atlantic Treaty Organization (NATO)

May 10—President Jimmy Carter of the U.S. addresses the representatives of the 15 member countries of the North Atlantic Treaty Organization, meeting in London; at the 2-day meeting, he proposes strengthening NATO to match increased Soviet military capabilities.

Organization of American States (OAS)

June 14—At St. Georges, Grenada, the Organization of American States begins its annual meeting; U.S. Secretary of State Cyrus Vance urges the assembled members to respect human rights.

Organization of Petroleum Exporting Countries (OPEC)

May 13—According to an oil industry newsletter, 11 OPEC members have agreed to postpone their planned 5 percent price rise for crude oil.

June 29—In Vienna, OPEC reports that 9 of its members are dropping plans for a 5 percent rise in the price of oil. Iraq and Libya have not agreed to drop their plan for a price rise.

Southeast Asian Treaty Organization (SEATO)

June 30—SEATO is dissolved.

United Nations

(See also *Mozambique*)

May 3—The World Health Organization, with representatives from 150 nations, opens its annual conference in Geneva.

June 4—The UNICEF board meeting in Manila, Philippines, approves $113.6 million in aid for 50 developing countries at its annual meeting.

World Bank

June 7—The World Bank and the International Development Association announce the granting of extensive loans and credit to Malaysia, India and Afghanistan; the Bank is loaning Malaysia $61 million; the IDA is extending $23 million in credit to India and, with Canada, is extending $16.7 million in credit to Afghanistan (IDA will provide $12 million).

ANGOLA

May 31—President Agostinho Neto says that hundreds of people have been arrested for their role in an unsuccessful coup May 27.

ARGENTINA

May 4—4 members of the 1971-1973 military junta, including former President Alejandro Lanusse, are arrested on charges of corruption in the financial arrangements of their administration.

May 7—Foreign Minister César A. Guzzetti is wounded in an attempt on his life.

June 4—The government announces the death of Montonero guerrilla leader Julio Roque; he was the last remaining member of the 4-member executive secretariat of the Montoneros.

AUSTRALIA

May 24—Prime Minister Malcolm Fraser imposes restrictions on the export of uranium.

BANGLADESH

May 30—A nationwide referendum is held to decide whether Major General Ziaur Rahman should remain as President.

June 1—The Election Commission reports that President Ziaur Rahman has won 99 percent of the vote.

BELGIUM

June 3—King Baudouin swears in the new coalition government headed by Prime Minister Leo Tindemans.

BRAZIL

(See *West Germany*)

BULGARIA

May 12—Longstanding Politburo member Boris Velchev is suddenly removed without explanation from his positions on the Central Committee, the Secretariat and the Politburo.

CANADA

May 7—At the conclusion of a conference, Premiers from 4 western provinces—British Columbia, Alberta, Saskatchewan and Manitoba—join Ontario in rejecting Quebec's proposal to retain economic ties with Canada if Quebec declares her independence.

June 3—Prime Minister Pierre Elliott Trudeau appoints Donald S. Thorson to the newly created post of constitutional adviser.

June 21—The federal government issues a policy statement endorsing the provision for English-language and French-language instruction in public schools in all Canadian provinces.

June 22—The federal government makes a temporary exception in Quebec to its guidelines on equal language instruction in public schools. The Quebec government will be permitted to require most schoolchildren to attend French-language schools.

CHILE

(See *U.S., Foreign Policy*)

CHINA

(See also *U.S., Foreign Policy*)

May 10—At the United Nations, Chen Chu assumes the position of chief delegate. He replaces Huang Hua, who resigned 6 months ago to become Foreign Minister.

June 1—Government officials report that the 1976 earthquake in Tangshan City was the most devastating in more than 4 centuries; the destruction covered an area 4 miles wide and 5 miles long in the center of heavily populated, industrial Tangshan City.

June 3—An article in the Communist party newspaper, *Jenmin Jih Pao*, claims that former Deputy Chairman Wang Hung-wen was the chief "agent provocateur" in the "Gang of Four."

June 6—In Peking, Sudanese President Gaafar al-Nimeiry meets with Chairman Hua Kuo-feng and senior Deputy Prime Minister Li Hsien-nien.

June 8—In Peking, Chairman Hua meets with Vietnamese Prime Minister Pham Van Dong.

CUBA

(See also *Ethiopia; U.S., Foreign Policy*)

June 3—Government officials announce that 10 of 30 American prisoners held on drug-related charges will be freed immediately and that the cases of the remaining 20 will be reviewed.

DJIBOUTI REPUBLIC

June 27—The former French territory of Afars and Issas becomes the Republic of Djibouti, the 49th independent state in Africa; the French have ruled the country for the last 115 years.

EGYPT

(See *U.S.S.R.; Zaire*)

EL SALVADOR

May 11—In San Salvador, the body of kidnapped Foreign

Minister Mauricio Borgonovo is found; he was kidnapped 3 weeks ago. Left-wing guerrillas claim he was killed in a "revolutionary war to establish socialism." President Arturo Armando Molina consistently refused to release 37 political prisoners in order to gain Borgonovo's release.

ETHIOPIA

May 4—Military strongman Lieutenant Colonel Mengistu Haile Mariam arrives in Moscow for talks with Soviet Foreign Minister Andrei Gromyko and President Nikolai Podgorny.

May 6—Tass, the Soviet press agency, reports that Mariam and Podgorny have signed agreements affirming friendly relations between the 2 countries and calling for Soviet economic assistance; no mention is made of military assistance.

May 25—In Washington, D.C., U.S. State Department spokesman Hodding Carter 3d reports that there are 50 Cuban military advisers currently serving in Ethiopia to train government forces in the use of Soviet military equipment.

June 1—The government calls home 81 military men currently receiving military training in the United States. It is estimated that since 1950, 23,000 Ethiopians have been trained in the U.S.

June 15—In Gondar Province, armed peasants and government troops recapture the town of Humera from the coalition forces of the Eritrean Liberation Front and the Ethiopian Democratic Union.

FRANCE

(See also *U.S.S.R.*)

May 20—At the conclusion of a 2-day meeting, the Independent Republican party of President Valéry Giscard d'Estaing changes its name to "the Republicans." Jean-Pierre Soisson is elected party president.

May 24—Nearly 5 million union members throughout the country stage a 24-hour strike to protest the government's austerity program.

June 8—The government announces its decision to assume a controlling interest in Avions Marcel Dassault-Breguet Aviation, the country's leading aircraft manufacturer.

Overseas Territories

AFARS AND ISSAS

(See also *Djibouti Republic*)

May 8—In a national referendum, 80 percent of the eligible voters vote for independence from France. Independence will be granted on June 27, 1977.

GERMANY, FEDERAL REPUBLIC OF (West)

May 5—Former Chancellor Ludwig Erhard dies at the age of 80.

May 12—Chancellor Helmut Schmidt returns from the 7-nation economic summit meeting in London.

May 25—The Cabinet approves a $250-million plan to aid unemployed workers.

June 17—In Bonn, Chancellor Schmidt announces an end to the export of nuclear reprocessing equipment. The sale of nuclear technology already contracted for by Brazil will be permitted.

GUINEA

June 7—In the U.N., the International League for Human Rights presents a report accusing Guinea of torturing and murdering political prisoners.

INDIA

May 1—In New Delhi, Defense Minister Jagjivan Ram announces the merger of his Congress for Democracy party with the ruling Janata party.

May 27—U.S. Ambassador to India Robert F. Goheen tells Prime Minister Morarji R. Desai that the U.S. will resume shipments of enriched uranium for a nuclear power plant in Bombay.

June 10—Elections for seats in assemblies of 10 of the 22 states begin; they will continue for 5 days.

June 15—Election returns show the Janata party of Prime Minister Desai winning in 8 of the 10 state assembly elections.

June 16—The Marxist Communist party of India wins a majority of assembly seats in West Bengal.

INDONESIA

May 2—Nationwide parliamentary elections are held.

May 31—Unofficial returns give the government party, GOLKAR, 62.1 percent of the vote; the Unity Development party wins 29.3 percent and the Indonesian Democracy party (PDI) wins 8.6 percent.

IRELAND

June 17—In yesterday's nationwide parliamentary elections, the coalition government headed by Prime Minister Ian Cosgrave is defeated by the Fianna Fail party led by former Prime Minister Jack Lynch. The Fianna Fail wins at least 75 of the 148 seats in the Dail (Parliament).

ISRAEL

(See also *U.S., Foreign Policy*)

May 18—In yesterday's election, the Labor party is defeated; the right-of-center Likud party wins 43 seats in the 120-member Parliament (61 seats are needed for a majority); the Labor party wins 33 seats, a loss of 18 seats since the 1973 election. The Likud party is led by Menahem Begin, who is expected to become the Prime Minister. Begin is a former leader of the Irgun Zvai Leumi, an underground terrorist group that fought the British in the 1940's.

May 24—In an attempt to form a coalition government with the Democratic Movement for Change, leaders of the Likud bloc state that the new government will not attempt to annex the West Bank area and the Gaza Strip as a formal part of Israel so long as peace talks continue with the Arabs.

June 7—President Ephraim Katzir formally asks Menahem Begin to form a new government.

June 20—Menahem Begin assumes the post of Prime Minister; he presents his cabinet to Parliament. Former Defense Minister Moshe Dayan is named Foreign Minister and Ezer Wizman is named Minister of Defense.

ITALY

June 7—The Senate defeats a liberal abortion bill by 2 votes; the Chamber of Deputies previously approved the bill.

June 29—The Christian Democrats agree to join forces with the Communist party in order to get economic legislation through the Parliament. This is the 1st formal alliance between the 2 parties since 1947.

JAMAICA

June 5—Prime Minister Michael Manley asks Governor General Florizel Glasspole to proclaim an end to the state of emergency declared 1 year ago; the Suppression of Crimes Act is to remain in effect.

JAPAN

May 17—In an attempt to prevent the imposition of higher U.S. tariffs, the government agrees to a reduction of 40.9 percent in the number of color television sets exported to the U.S. over the next 3 years.

KENYA

May 19—In an effort to preserve the country's wildlife, the government outlaws all big-game hunting; Minister for Tourism Matthew Ogutu cancels all hunting licenses and forbids anyone with firearms for hunting to enter the country.

June 29—In Nairobi, it is reported that on June 27 3,000 Somali troops attacked a Kenyan border post; 7 Somalis and 6 Kenyans were killed.

KOREA, REPUBLIC OF (South)

(See also, *U.S., Political Scandal*)

June 5—The South Korean government and the Japanese government are informed by U.S. officials that 6,000 American soldiers will be withdrawn from South Korea by the end of 1978. This is the first stage of a withdrawal of 33,000 American soldiers.

MEXICO

May 11—Attorney General Oscar Flores Sanchez announces the release of about 2,000 Mexicans and foreigners, including some 100 Americans, currently held in prison on drug-related charges.

June 20—The U.S. Immigration and Naturalization Service permits more than 800 crop pickers to enter the U.S. in southwestern Texas despite the objections of the U.S. Labor Department.

June 21—Between 50 and 60 American citizens are being released from jails where they were serving sentences on drug-related charges.

MOROCCO

June 4—Returns from yesterday's nationwide parliamentary elections show that independents and rightists won a clear majority of seats. King Hassan is supported by the independents, who won 81 of 176 seats; 3 right-wing parties won 33 seats.

MOZAMBIQUE

May 31—Rhodesian government troops capture Mapai, a black nationalist guerrilla camp 50 miles inside the Mozambique border; 20 guerrillas are killed.

June 18—President Samora Machel asks the U.N. Security Council to hold an emergency session because of the recent Rhodesian raid.

June 29—The U.N. Security Council agrees to provide "material assistance" to the government to help it protect its border areas from Rhodesian troops.

June 30—The U.N. Security Council asks U.N. members to send "material" aid to Mozambique.

NAMIBIA (Southwest Africa)

May 18—In a countrywide referendum, 95 percent of eligible white voters overwhelmingly support South Africa's plan for a multiracial interim government. The referendum is not acceptable to the U.N.

June 10—In Cape Town, the South African government announces that it will appoint an administrator-general for Namibia, which it regards as South African territory, instead of proceeding with the transitional government originally proposed.

NETHERLANDS

(See also *Intl, Intl Terrorism*)

May 25—Nationwide parliamentary elections are held; all 150 seats in the lower house are being contested.

June 28—Complete parliamentary election returns give the Labor party 33.8 percent of the vote or 53 seats; the Christian Democratic Alliance 31.9 percent or 49 seats; and the Liberals 17.9 percent or 28 seats.

PAKISTAN

May 5—Police arrest leaders of the opposition Pakistan National Alliance. The radio announces the imposition of curfews in Lahore, Karachi and Hyderabad.

May 7—In Lahore, Pakistani soldiers kill 2 men and wound 11 others as they attempt to control demonstrators; 250 people, members of the National Alliance, are reportedly arrested. It is estimated that 50,000 people are being detained because of their opposition to Prime Minister Zulfikar Ali Bhutto.

May 13—In an address to the Assembly, Bhutto announces his decision to hold a referendum to permit the electorate to decide whether he should remain in power. No date is set for the referendum.

June 3—Following talks between Prime Minister Bhutto and leaders of the opposition Pakistan National Alliance, the government agrees to release the last 3 detained opposition political leaders and other political prisoners and to end press censorship.

June 7—Martial law in Lahore, Karachi, and Hyderabad is lifted.

June 14—The government and the opposition agree to hold new elections before the end of 1977.

PERU

June 22—Student demonstrators rally in 5 provinces to protest the government's recently announced austerity measures, which include a 50 percent increase in the price of gasoline and a 30 percent increase in public transit fees.

PHILIPPINES

June 3—In Manila, President Ferdinand E. Marcos says that military tribunals will be phased out and that the cases previously heard by the tribunals will be transferred to civilian courts.

RHODESIA

(See also *Mozambique*)

May 6—In London, U.S. Secretary of State Cyrus R. Vance and British Foreign Secretary David Owen reach agreement on a policy toward Rhodesia. A Geneva-type conference is ruled out in favor of a series of low-level meetings with various African leaders.

May 9—Fighting is reported between government forces and black nationalist guerrillas 200 miles south of Salisbury; 37 civilians are reported killed and 31 civilians injured.

June 10—In London, Commonwealth leaders agree to support U.S. and British proposals to work for a peaceful transition to black rule in Rhodesia.

SAUDI ARABIA

(See also *U.S., Foreign Policy*)

May 24—In Washington, D.C., Crown Prince Fahd meets with U.S. President Jimmy Carter.

May 30—Riyadh Radio reports that the government has

decided to nationalize foreign-owned banks within a year.

SEYCHELLES

June 5—The government-controlled radio reports that dissident leftists led by Prime Minister F. Albert René have ousted President James R. M. Mancham while he was attending the Commonwealth Conference in London. Parliament and the constitution are suspended.
June 7—In Victoria, the 24-hour curfew is relaxed.
June 8—President René says the country will not turn to Marxism but will develop a socialist form of government designed to meet the needs of the country.

SOMALIA

(See *Kenya*)

SOUTH AFRICA

(See also *Namibia; U.S., Foreign Policy*)

May 11—Complying with an official request from the U.S. government, the South African government approves a visit by U.S. Representative to the U.N. Andrew Young on May 21.
May 19—In Vienna, Prime Minister John Vorster meets with U.S. Vice President Walter Mondale.
June 3—The government extends mandatory service for white males in the armed forces from 1 to 2 years.
June 13—3 black men carrying submachine guns kill 2 white men and seriously injure a 3d person near police headquarters in Johannesburg.
June 16—In suburbs outside Uitenhage on the anniversary of last year's rioting, police open fire on a gang of youths maurauding in the streets. 8 blacks are reported killed by police and 2 are burned to death.
June 23—In Johannesburg, hundreds of blacks stage a protest in the downtown section of the city.
June 24—Foreign Minister Roelof F. Botha concludes a week-long visit in Washington, D.C., where he met with U.S. Secretary of State Cyrus R. Vance.

SPAIN

(See also *U.S.S.R.*)

May 5—King Carlos receives the credentials of Ambassador from the Soviet Union Sergei A. Bogomolov, the first Soviet ambassador to Spain in 38 years.
May 6—The Interior Ministry refuses to register 67 political parties for the June 15 election; to date 156 parties have registered.
May 13—Dolores Ibarruri, an 81-year old Spanish Communist party leader, returns to Spain from 38 years in exile in the Soviet Union.
May 21—Prime Minister Adolfo Suárez declares amnesty for 110 political prisoners if they agree to leave the country for the duration of their sentences.
June 16—In yesterday's elections, the Union of the Democratic Center, the coalition party led by Prime Minister Adolfo Suárez, wins 106 of the 207 seats in the Senate and about 170 seats in the 350-member House; the Socialist Workers party receives 115 seats in the House and 60 in the Senate.
June 17—King Carlos asks Prime Minister Suárez to retain his post and form a new government.
June 22—In Madrid, Prime Minister Suárez meets with Communist party secretary general Santiago Carrillo; this is the first known meeting between the 2 leaders.
June 26—The Spanish Communist party's Central Committee publishes a document rejecting the recent Soviet criticism in *New Times* (Moscow) of Santiago Carrillo and the theory expounded in his book on Eurocommunism.

SUDAN

(See also *China*)

May 18—The government shuts down the military department of the Soviet embassy in Khartoum and expels all 90 Soviet military advisers.

SYRIA

(See also *U.S., Foreign Policy*)

June 19—In Damascus, Brigadier Abdul Hamid Razouk, head of the army's missile corps, is assassinated by unidentified gunmen.

TURKEY

June 6—In yesterday's nationwide parliamentary elections, the Republican Peoples' party, headed by former Prime Minister Bulent Ecevit, wins 213 seats in the 450-member Parliament, 13 seats short of a majority; the Justice party of Prime Minister Suleyman Demirel wins 189 seats; and the party of National Salvationists, an orthodox Muslim party, wins 24 seats.
June 9—In Rome, Turkey's ambassador to the Vatican, Taha Carim, is killed by an unidentified gunman.
June 14—President Fahri Koruturk asks Bulent Ecevit to form a new government.

UGANDA

(See also *Intl, Commonwealth Conference*)

June 8—The government orders all British citizens to remain in Uganda and forbids them to meet in groups of more than 3.
June 9—Robert Scanlon, a British citizen, is arrested on charges of spying.
June 15—In London, the Commonwealth conference condemns the government of Idi Amin for its "disregard for the sanctity of human life" and its "massive violation of basic human rights."
June 25—A radio report from Nairobi, Kenya, says that President Amin is back in public view after a week's "disappearance" and that he denies reports of an attempt to kill him.

U.S.S.R.

(See also *Ethiopia; France; Spain; U.S., Foreign Policy*)

May 18—In Geneva, talks begin between Foreign Minister Andrei A. Gromyko and U.S. Secretary of State Cyrus Vance on an arms limitation treaty.
May 23—In Moscow, the draft of a new constitution is approved by a commission chaired by Communist Party Secretary Leonid I. Brezhnev. The new constitution will replace the document prepared in 1936 under Premier Josef Stalin.
May 24—The Communist party's central committee votes to remove President Nikolai V. Podgorny from the Politburo. No explanation is given.
June 4—A draft of the new constitution is made public in newspapers throughout the country; it provides for a new post, a first deputy chairman of the Presidium of the Supreme Soviet.
June 8—In Moscow, Egyptian Foreign Minister Ismail Fahmy meets with Foreign Minister Andrei A. Gromyko. Fahmy is also scheduled to meet with Brezhnev.
June 11—In Moscow, Robert C. Toth, an American correspondent, is detained by police on charges of receiving stolen scientific secrets.

June 16—Podgorny resigns as President.

The Supreme Soviet names Brezhnev President. He is the 1st person to hold the post of President and Secretary General of the Communist party simultaneously.

After 13 hours of questioning, Toth is allowed to leave the country.

June 20—In Paris, Brezhnev is greeted by French President Valéry Giscard d'Estaing. The 2 leaders are scheduled to discuss "détente and the guarantee of the security of peoples."

June 23—*New Times*, a foreign affairs weekly, carries an editorial criticizing a book entitled *Eurocommunism and the State*, by Spanish Communist party leader Santiago Carrillo.

UNITED KINGDOM

Great Britain

May 11—Prime Minister James Callaghan names Peter Jay, his son-in-law, as Ambassador to the U.S.

May 19—In London, the *Daily Mail* reports that the British Leyland Company, a state-owned automobile manufacturer, paid more than $60 million in bribes since 1975 to obtain export orders.

June 6—Queen Elizabeth II officially begins her Silver Jubilee with a week-long commemoration of her 25 years as Queen.

June 25—The unemployment figure for mid-June is reported at 6.2 percent, nearly the highest level since World War II.

Northern Ireland

May 3—Militant Protestants led by Reverend Ian Paisley begin a general strike. The British government sends additional troops to Ulster after the failure of talks with the Ulster Unionist Action Council.

May 14—The strike ends; Paisley admits it was only partially successful.

May 27—In Belfast, 5 men thought to be members of the Irish Republican Army are arrested and charged with the murder of British Captain Robert Nairac, who disappeared May 14.

UNITED STATES

Administration

May 5—The White House press office reports the appointment of Washington, D.C., lawyer Thomas Farmer to head the Intelligence Oversight Board; the President's Foreign Intelligence Advisory Board is to be eliminated.

May 11—Commissioner of Food and Drugs Donald Kennedy and the heads of the Environmental Protection Agency and the Consumer Products Safety Commission propose that spray cans using chlorofluorocarbons as propellants be phased out and banned within 2 years.

May 15—Experts at the U.S. Department of Agriculture report that for the 1st time in 5 years adequate world wheat supplies guarantee that crop failures will not bring on a broad food crisis anywhere in the world.

May 16—A 2½ year study sponsored by the Massachusetts Institute of Technology reports that a world oil shortage is inevitable by the 1980's.

May 25—Chief Watergate Prosecutor Charles Ruff announces that his office will close in June.

May 26—President Jimmy Carter names John G. Heiman as Comptroller of the Currency.

At a White House news conference, President Carter warns that he will veto bills that mean excessive spending increases; the President also warns against increases in federal spending for welfare purposes.

May 28—It is reported that United States Passport Office head Frances Knight has been told by her State Department superiors that she must retire on July 31; she has had two 1-year extensions since she reached the mandatory retirement age of 72.

June 8—At a news briefing at the White House, White House press secretary Jody Powell says that President Jimmy Carter's 1975 income tax return is being audited by the Internal Revenue Service.

June 11—According to a report by the National Academy of Sciences, released today in Washington, D.C., the Veterans Administration medical program is wasteful and delivers dangerously poor care to some patients in its hospitals.

June 14—In a news conference at the White House, President Carter warns that he sees the country facing catastrophe if "special interests" are able to block an "adequate" energy program.

The U.S. Court of Appeals for the Second Circuit in New York reverses a May 11 lower court ruling and agrees that the Port Authority of New York and New Jersey can legally ban SST Concorde flights into Kennedy International Airport as long as the ban is "fair, reasonable, and nondiscriminatory."

June 17—The Environmental Protection Agency approves the thermal discharge system of the Seabrook, New Hampshire, nuclear power plant after a 2-year delay; the Nuclear Regulatory Commission has final responsibility to authorize construction.

June 19—U.S. troops and equipment are starting a $20-million, 2-year cleanup and decontamination project on Enewetok, the Marshall Islands site of U.S. nuclear testing; the project's ultimate aim is to permit the return of the islanders; they were removed from their homeland when the island was used for tests.

June 23—Under the Safe Drinking Water Act of 1974, the Environmental Protection Agency begins to set standards and monitor the quality of the nation's drinking water.

June 24—Although he legally owes nothing on his 1976 income tax, President Carter asks the IRS to accept his voluntary $6,000 payment.

June 30—In a press conference, President Carter announces that in view of the development of the cruise missile, a low-flying drone, he has ordered a halt in the production of the controversial B-1 strategic bomber.

Secretary of Transportation Brock Adams publishes an order requiring the installation of automatic seat belts or air bags in all standard and luxury cars by 1982 and in all smaller cars by 1984.

Civil Rights

(See also *U.S., Supreme Court*)

May 1—More than half of some 2,000 demonstrators at a nuclear energy plant are arrested in Seabrook, New Hampshire; the demonstrators call themselves the Clamshell Alliance.

May 13—The nuclear protesters in detention in New Hampshire are released on their own recognizance pending appeal, after they are found guilty in district court on trespassing charges.

June 6—A memorandum issued by Attorney General Griffin Bell notes that HEW has the authority to deny federal funds to school districts that refuse to merge black and white schools, a "pairing" that usually requires some busing.

June 10—The Columbus, Ohio, school board votes to approve a desegregation plan ordered March 8 by U.S. district court Judge Robert Duncan.

Economy

May 10—The Commerce Department says that personal income grew by 9.1 percent in 1976; average per capita income was $6,441 in 1976.

May 11—Major steel companies are rolling back price increases to the 6 percent increase announced May 9 by United States Steel Corporation.

May 27—The Commerce Department announces a 0.5 percent increase in its index of economic indicators for April.

June 3—The Labor Department reports employment in May at 90,408,000, with unemployment falling to 6.9 percent, the lowest level in 30 months.

June 20—The Commerce Department reports a revised estimate of the gain in the gross national product (GNP); it is estimated at 6.9 percent for the first quarter of 1977.

June 21—The Labor Department reports an 0.6 percent rise in the consumer price index in May; the increase for April was 0.8 percent.

June 22—The Commerce Department shows a $4.3 billion deficit in the U.S. balance of payments for the first quarter of 1977.

June 29—The Commerce Department reports a 0.2 percent drop in the leading economic indicators for May.

Foreign Policy

(See also *Korea*)

May 5—President Carter arrives in London for summit talks with the heads of state of Great Britain, France, West Germany, Italy, Canada and Japan.

The seized Russian fishing trawler *Tara Shevchenko,* the first vessel detained by the U.S. Coast Guard for violation of the new U.S. 200-mile fishing limit zone, is released after payment of a $240,000 fine.

New York Times journalist William Shannon is named by President Carter as U.S. Ambassador to Ireland.

May 8—President Carter meets with British Conservative party leader Margaret Thatcher.

May 9—Leaders of the U.S., France, Great Britain and West Germany meet in a special short conference in London and issue a communiqué declaring that the existing agreements with the Soviet Union on Berlin are "indispensable to . . . the strengthening of détente, the maintenance of security, and the development of cooperation throughout Europe."

President Carter meets with French President Valéry Giscard d'Estaing in London and then flies to Geneva to meet Syrian President Hafez al-Assad to discuss Middle East peace prospects; the President also meets President Kurt Furgler of Switzerland in Geneva.

U.S. Representative to the U.N. Andrew Young leaves on a trip to African countries.

May 10—President Carter addresses the opening session of a 2-day NATO meeting in London.

President Carter returns to the U.S.

In Abidjan, Ivory Coast, Andrew Young meets with 33 U.S. diplomats from African posts to discuss U.S. policies toward Africa.

May 11—Secretary of State Cyrus Vance flies to Madrid, Spain, for a 20-hour visit with Spanish officials.

May 13—Vice President Walter Mondale leaves for Europe.

May 15—Vice President Mondale and U.N. delegate Andrew Young meet in Lisbon, Portugal, to coordinate their diplomacy toward Africa.

May 18—Secretary of State Vance and Soviet Foreign Minister Andrei Gromyko open discussions on arms limitation agreements in Geneva.

May 19—President Carter recalls Major General John Singlaub, chief of staff of the U.S. forces in South Korea, for conference; the general has publicly disagreed with the President's decision announced March 9 to withdraw all U.S. troops from South Korea in 4 or 5 years.

In a policy statement, President Carter announces broad future restrictions on the sale of U.S. weapons to other countries.

May 20—Secretary of State Vance and Soviet Foreign Minister Andrei Gromyko conclude 3 days of talks in Geneva; they agree on a formula to end the impasse in the strategic arms limitation talks.

Meeting in Vienna with South African Prime Minister John Vorster, Vice President Mondale asks Vorster to end South African apartheid policies. Vorster refuses to modify his policies.

Vice President Mondale flies to Belgrade, Yugoslavia, for talks with Yugoslav President Tito.

May 21—President Carter orders the Defense Department to reassign Major General John Singlaub.

May 22—Speaking in South Bend, Indiana, President Carter outlines a broad American foreign policy more responsive to humanitarian problems; he warns that it is necessary to act now to reach a settlement in the Middle East.

Speaking to black leaders in Johannesburg, South Africa, Andrew Young suggests that black South Africans could mount an economic boycott against apartheid.

May 23—Vice President Mondale returns to the U.S.

May 25—President Carter concludes 2 days of talks with Saudi Arabian Crown Prince Fahd. Fahd has reportedly assured the President that there will be no oil embargo against the U.S. as a diplomatic lever against Israel.

The U.S. Court of Appeals for the Second Circuit extends a stay barring Concorde supersonic plane flights to Kennedy International Airport until June 1.

May 26—President Carter signs the Treaty of Tlatelolco, which makes Latin America a nuclear-free zone; the U.S. will not manufacture, use, or store nuclear weapons in its Latin American bases; 21 Latin American countries have already ratified the treaty.

May 27—Major General John Singlaub is reassigned as commanding officer of the Army Forces Command at Fort McPherson, Georgia.

May 30—Rosalynn Carter leaves on a trip to 7 Latin American countries.

President Carter names Gerard Smith as Ambassador at Large for negotiations on nuclear issues; Smith was director of the U.S. Arms Control and Disarmament Agency in the administration of President Richard Nixon.

June 1—The State Department says that negotiations with Panama over a new Panama Canal treaty will be recessed until June 10.

June 3—State Department spokesman John Trattner announces an agreement with Cuba after 2 months of negotiations; each country will maintain an "interest section" of diplomats and consular officials in the other country's capital.

June 7—According to government sources, the U.S. will not allow the Northrop Corporation to sell 250 F-18L jets to Iran.

June 12—Rosalynn Carter returns from a 7-nation 14,000-mile tour of Latin America.

June 15—The State Department announces that Secretary of State Cyrus Vance and Soviet Foreign Minister Andrei Gromyko will not meet again until September.

June 17—In a speech in San Francisco, Vice President Walter Mondale says that the U.S. believes that Israel should not be expected to withdraw from occupied Arab lands unless she can obtain "real peace" from the Arab states.

June 21—In Moscow, Paul Warnke, chief U.S. arms negotiator, starts to discuss plans for demilitarizing the Indian Ocean.

June 22—U.S.-British negotiators agree on a new treaty on aviation rights, averting a halt in plane service between the U.S. and Britain.

June 23—The Commerce Department refuses to permit the Control Data Corporation to sell a Cyber-76 computer to the Soviet Union; the export license is refused on the grounds that the advanced computer could be diverted to military use.

June 25—A White House release reports that President Carter recommends a proposed sale of $115 million in arms for Israel.

June 28—State Department spokesman Hodding Carter 3d releases a statement on U.S. Middle East policy that asks Israel to relinquish some occupied territories and to consider a Palestinian homeland in return for a secure peace with the Arab countries.

State Department spokesman Hodding Carter 3d says that because of Chile's stand on human rights the department is temporarily holding up 2 Chilean loans totaling nearly $10 million that were to be used to aid Chilean farmers.

June 29—Cyrus Vance declares that friendly relations with China and full diplomatic recognition are central goals of U.S. foreign policy.

Labor and Industry

June 14—Arnold Miller is elected to a second 5-year term as president of the United Mine Workers of America.

June 20—Oil starts to flow into the 799-mile trans-Alaskan pipeline on its approximately 30-day trip to the ice-free port of Valdez.

Legislation

May 13—President Jimmy Carter signs a $4-billion economic stimulus bill and an appropriation bill of $20 billion to pay for that program and to create jobs in construction and related industries; the bills are expected to create 1 million jobs. Congressional action on the economic stimulus bill was completed May 3; the $20-billion appropriation bill was approved May 2 in final form.

May 23—President Carter signs the Tax Reduction and Simplification Act of 1977; taxes will be reduced by $34.2 billion over the next 28 months and low and middle income taxpayers will save over $5 billion in 1977; the measure also simplifies filing procedures and provides tax credits for business, in order to create more employment.

June 22—President Jimmy Carter signs a bill designed to limit American corporate involvement in the boycott by Arab countries against Israel.

June 29—The Senate votes 56 to 42 to defeat a measure that would have removed the ban on the use of federal funds for abortions except in cases of rape, incest or specific medical necessity. The anti-abortion measure is an amendment to appropriations for HEW.

Military

(See also *Administration, Foreign Policy*)

May 8—Secretary of Defense Harold Brown instructs military intelligence agencies to conduct their operations "strictly within the law."

Political Scandal

May 4—Former President Richard Nixon is interviewed by David Frost in a 90-minute taped television program, the 1st of 4 taped programs; the former President answers questions about the involvement of his aides in Watergate and the cover-up. It is reported that Nixon will be paid $600,000 plus 10 percent of the profits from the sale of the taped programs, owned by Frost.

May 12—In a 2d television interview, Nixon discusses his diplomacy.

May 19—In a 3d television interview, Nixon defends his actions against dissident Americans.

May 25—The 4th interview between Nixon and Frost is released.

May 30—Federal investigators report that various South Korean groups tried to gain control of the Diplomat National Bank of Washington.

June 4—Former director of the Korean Central Intelligence Agency Kim Hyung Wook identifies Park Tong Sun as an agent who spent enormous sums of money, allegedly to influence U.S. foreign policy about South Korea.

June 21—Former White House chief of staff H. R. Haldeman begins serving a 2½ to 8-year prison term for his part in the Watergate scandal.

June 22—Former Attorney General John Mitchell enters prison to serve his term of 2½ to 8 years for his involvement in the Watergate scandal.

Politics

May 2—Reports on file with the Federal Election Commission, released today, show that in congressional elections in 1976 winners spent more than $55 million. They collected $60 million for their campaigns; $5 million is unaccounted for.

May 12—The Federal Election Commission orders Pennsylvania Governor Milton Shapp to return almost $300,000 in public subsidies he received in his 1976 presidential campaign; the commission claims he was not eligible for the full subsidy.

May 13—Governor Shapp denies any improper behavior in the financing of his campaign for the presidency; he says he will repay almost $300,000 in federal subsidies.

June 23—In New York, President Jimmy Carter attends a fund-raising dinner given by the Democratic National Committee; more than $1 million is raised for the Democratic party.

Supreme Court

May 16—By a 7-2 vote, the Supreme Court refuses to review the decision of a lower court that had ordered broad procedural protections for children facing commitment to mental institutions at the request of their parents.

May 23—With Justice William Rehnquist not participating, the Court refuses to hear the appeals of John Mitchell, H. R. Haldeman and John Ehrlichman; they are appealing their convictions for taking part in the Watergate break-in or cover-up.

By a 5-4 vote, the Court rules that individuals are subject to the federal ban on sending obscene material through the mail even if a state law is more permissive

and would permit the mailing. The case involves an Iowa law.

May 31—By a 7-2 vote, the Supreme Court rules that Title VII of the Civil Rights Act of 1964 does not prevent the continued "routine application" of seniority systems in employment "even where the employer's pre-act discrimination resulted in whites having greater existing seniority rights than Negroes."

June 6—By a 5-4 decision, the Supreme Court rules that a state law establishing the death penalty as mandatory, automatic punishment for anyone convicted of murdering a police officer is not constitutional.

June 13—By a 9-0 vote, the Supreme Court upholds New York State procedures that permit the removal of foster children from foster families without preliminary hearings except in certain specific cases—i.e., when a child has been with a foster family for 18 months or when a foster parent requests the preremoval hearing.

June 20—The Supreme Court rules 6 to 3 that states, cities and towns with public hospitals are not required under the constitution to provide or even permit elective abortions using Medicaid funds.

In a 5-4 ruling, the Court upholds Department of Health, Education and Welfare regulations under Aid to Families with Dependent Children that allow states to refuse welfare benefits to children of fathers who are unemployed voluntarily, because of a strike or misconduct.

June 21—The Court unanimously upholds a lower court ruling that the Fourth Amendment requirement that police procure warrants before conducting searches cannot be limited to situations in which the individual has a strong privacy interest. The Justice Department sought the limitation.

June 23—The Court rules 7 to 2 that prison authorities may prohibit inmates from unionizing or operating previously formed inmate unions.

June 24—In a series of rulings, the Court holds that states may provide financing for "general welfare" services to children in parochial schools, provided the services are provided at a "neutral site" off the school premises.

June 27—By a unanimous decision, the Supreme Court upholds a Detroit, Michigan, lower court decision that in school desegregation cases federal courts may order school districts to provide and pay for remedial classes to assist disadvantaged students to overcome their poorer educational backgrounds.

By an 8-0 vote, the Court upholds lower court decisions giving the federal courts the authority to order city-wide school desegregation, including busing.

In a 5-4 vote, the Court rules that lawyers cannot constitutionally be prohibited from advertising the fees they charge for routine legal services.

June 28—In a 7-2 opinion, with Chief Justice Warren Burger and Justice William Rehnquist dissenting, the Supreme Court upholds the Presidential Recordings and Materials Preservation Act of 1974 which gave the government control of former President Richard Nixon's presidential papers and tape recordings. Nixon filed suit on December 20, 1974, challenging the constitutionality of the law signed by President Gerald Ford on December 19, 1974; the majority opinion holds that Nixon was "a legitimate class of one" subject to special treatment.

June 29—The Court rules 6 to 3 that the death penalty for the crime of rape of an adult is an "excessive" punishment and therefore unconstitutional.

The Court lifts an injunction that prevented the barring of federal funds for abortions. (See also *Legislation*.)

Terrorism

May 3—12 members of the Hanafi Muslims are indicted on murder charges and other charges in Washington, D.C., for acts committed in their takeover of 3 Washington buildings and hostages in March, 1977.

May 9—Patricia Hearst is placed on probation for 5 years for her part in a 1974 robbery and shooting incident in California after she was kidnapped by the so-called Symbionese Liberation Army.

VATICAN

June 19—Pope Paul VI proclaims American Bishop John Neumann a saint. Bishop Neumann, who died in Philadelphia in 1860, is the 1st male American saint.

VENEZUELA

June 28—President Carlos Andrés Pérez arrives in Washington, D.C., and meets with U.S. President Jimmy Carter.

VIETNAM

(See also *China*)

May 3—In Paris, Deputy Foreign Minister Phan Hien meets with U.S. Assistant Secretary of State for Asian and Pacific Affairs Richard Holbrooke at the beginning of negotiations to normalize relations between the 2 countries.

May 14—The governments of Vietnam, Thailand and Laos agree to reactivate the Mekong River Development Project.

May 20—The Vietnam news agency announces an extension of off-shore fishing limits to 200 miles.

June 3—In Paris, Vietnamese officials release information on 20 Americans reported missing in action (MIA's) during the war.

YUGOSLAVIA

(See also *U.S., Foreign Policy*)

May 21—In Belgrade, U.S. Vice President Walter Mondale meets with President Tito.

ZAIRE

May 1—In Cairo, Egyptian President Anwar Sadat announces that he will send Egyptian pilots to help the Zaire air force put down the rebellion in Shaba Province.

May 7—The combined forces of Moroccan and Zairian soldiers recapture the town of Sanikosa in Shaba Province. They reportedly retook the town of Kawayongo yesterday.

May 21—President Mobutu Sese Seko announces the capture of Dilolo on the Angolan border.

May 26—The government reports that its troops recaptured Kapanga, the last stronghold of the rebel forces. ■

Erratum: The editors regret an error in the May/June issue on *Health Care in America* in the article "Federal Involvement in Health Care after 1945," by Leda Judd. Lines 25-26 on page 227 should read: "During 1976, it [Medicaid] provided medical services for 23 million Americans—1 out of every 10 . . . ."

Proposed Health Insurance Pla

NAME OF BILL	KNOWN AS	NATIONAL SUPPORT	ESTIMATED COST, 1980	ADMINIS-TRATION
Health Security Act H.R. 21; S. 3	**Kennedy-Corman**	A.F.L.-C.I.O., Committee for National Health Insurance.	$24.8 billion.	Special board in HEW; regional and local offices will operate program.
Comprehensive Health Insurance Act of 1974 H.R. 4747	**CHIP**	Similar to HR 12687 supported by Nixon admin.	$11.3 billion.	Insurance throug private carriers; states to supervis under federal regulation.
National Health Care Services Reorganization and Financing Act H.R. 1	**Ullman**	American Hospital Association.	$25.1 billion.	Private insuranc carriers under state supervision according to fede guidelines.
Comprehensive Health Care Insurance Act of 1975 H.R. 6222	**Fulton**	American Medical Association.	$20.3 billion.	Insurance provic by private carrie under state supe vision; regulatio issued by a new federal board.
National Health Care Act of 1975 H.R. 5990; S. 1438	**Burleson-McIntyre**	Health Insurance Association of America.	$11 billion.	Insurance admin istered by privat carriers under st supervision; plar voluntary. Treas Dept. determine tax status.
Catastrophic Health Insurance and Medical Assistance Reform H.R. 10028; S. 2470	**Long-Ribicoff**	No formal support.	$9.8 billion.	Employers and employees can jo federal insurance program admini tered by HEW o buy private insu ance from federa approved carrier under HEW sup vision.

he United States, 1977-1978

FINANCING	BENEFITS	PATIENT COST SHARING
·om federal general ıes; half from special 1 percent of payroll for yees, 2.5 percent for yers and self-employed.	Institutional services: hospital care, skilled nursing facilities up to 120 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health services, prescription drugs (for chronic illnesses), medical appliances and ambulance services. Other services: physical checkups, well-child care, maternity, family planning, dental care (up to age 25), vision care and eyeglasses, hearing care and hearing aids.	None
ɔyer-employee pre- payments, with em- paying 75 percent rcent in first three ; special provisions for employers and those ıigh increases in payroll	Institutional services: hospital care, skilled nursing facilities up to 100 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health services (up to 100 visits), prescription drugs, medical supplies and appliances. Other services: well-child care, maternity, family planning, dental care (under age 13), hearing care and hearing aids (under age 13).	Annual deductible* of $150 per person; 25 percent coinsurance,** with annual ceiling of $1,500 per family.
ɔyer-employee pre- payments, with em- paying at least 75 per- ederal subsidy for low- e workers and certain employers; patients ing in a health-care ation get 10 percent y; individuals pay own ım.	Institutional services: hospital care up to 90 days, skilled nursing facilities (30 days), health-related custodial nursing home care (90 days). Diagnosis and treatment: physicians' services up to 10 visits, lab and X-ray, home health services (100 days), prescription drugs limited to specified conditions, medical supplies and appliances. Other services: physical checkups, well-child care, maternity, dental care (under age 13), vision care and eyeglasses (under age 13).	Coinsurance (20 percent) or co-payments*** (up to $5) on most items; special "catastrophic" provisions become effective when patient's out-of-pocket expenses reach a specified amount.
ɔyer-employee pre- payments, with em- paying at least 65 ıt of cost; small em- s get federal help as do ployers with unusual l cost increases; self- yed pay own premiums e assisted by income- ɛdits computed on a ; scale (the lower the e, the higher the cred- remiums for unem- l paid by federal ıment.	Institutional services: hospital care, skilled nursing facilities to 100 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health services, medical supplies and equipment. Preventive and special services: physical checkups, well-child care, maternity, family planning, dental care (under age 18).	Coinsurance of 20 percent, with an annual maximum of $1,500 per individual and $2,000 per family.
ɔyer-employee pre- payments, the ratios ıegotiated; low-income rs pay less; self-em- l pay entire premium; ticipants eligible for l tax deductions.	Institutional services: hospital care, skilled nursing facilities to 180 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health care (270 days), prescription drugs, medical supplies and appliances. Other services: well-child care, maternity, family planning, dental care (under age 13, one visit), vision care (under age 13, one visit).	Annual deductible of $100 per person; 20 percent coinsurance on all items, with annual family limit of $1,000.
ɔyers pay 1 percent l tax. Similar provi- or self-employed.	Institutional services: after 60 days, hospital care, skilled nursing facilities up to 100 days. Diagnosis and treatment: after an expenditure of $2,000, physicians' services, lab and X-ray, home health services, medical supplies and appliances. Other services: none.	First 60 days of hospitalization not covered; first $2,000 in family medical expenses not covered.

*Deductible: Patient's share of annual medical costs before insurance coverage begins.
**Coinsurance: the percentage of a given bill that is charged to the patient.
***Copayment: a flat rate charged to the insured patient on specific items (such as $2 per office visit).

Available From Current History

Academic Year 1977-1978

- ☐ Health Care in America: An Overview (5-6/77)
- ☐ Improving Health Care in America (7-8/77)
- ☐ The People's Republic of China, 1977 (9/77)
- ☐ The Soviet Union, 1977 (10/77)
- ☐ West Europe, 1977 (11/77)
- ☐ Africa, 1977 (12/77)
- ☐ The Middle East, 1978 (1/78)
- ☐ Latin America, 1978 (2/78)
- ☐ The World Energy Crisis (3/78)
- ☐ East Europe, 1978 (4/78)

Still Available

AREA STUDIES

- ☐ Canada, 1977 (4/77)
- ☐ Mexico, 1977 (3/77)
- ☐ Latin America, 1977 (2/77)
- ☐ The Middle East, 1977 (1/77)
- ☐ Southeast Asia, 1976 (12/76)
- ☐ Africa, 1976 (11/76)
- ☐ The Soviet Union, 1976 (10/76)
- ☐ The People's Republic of China, 1976 (9/76)
- ☐ Scandinavia and the Low Countries (4/76)
- ☐ Nations of East Europe (3/76)
- ☐ Latin America, 1976 (2/76)
- ☐ The Middle East, 1976 (1/76)
- ☐ World Food Resources (6/75)
- ☐ Japan in the Seventies (4/75)
- ☐ Nations of West Europe (3/75)

AMERICAN ISSUES

- ☐ Criminal Justice in America (6/76)
- ☐ Reforming the Criminal Justice System (7-8/76)
- ☐ Women in America (5/76)
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